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ABSTRACT

A review of European, Canadian, and United States child-care models is presented as the rationale for the implementation of a training program for child care professionals. The training model is described in terms of: (1) the child mental health specialist's role; (2) curricula and teaching activities; (3) internship and field experiences; (4) trainee recruitment and selection; (5) resources and training staff; and (6) the overall assessment of the program by trainees and employers. The findings of program effects focus on the need to develop a national, uniform training program and to integrate academic and real-life experiences during the training experience. Implications of these findings are related to future child-care patterns such as the development of specially trained child mental health care workers, the inclusion of child mental health training into teacher training programs, and the dissemination of child mental health and child care knowledge to individuals working with children. Tables outline the courses, training requirements at various educational levels, and the employment possibilities for program graduates of this model training program. (Author/HLM)

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A MODEL TRAINING PROGRAM
FOR A NEW CHILD-CARING PROFESSIONAL
FOR
A BROAD SPECTRUM OF SERVICES
IN CHILD MENTAL HEALTH AND EDUCATION

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FINAL REPORT TO THE NIMH
Grant Number 5 T21 MH 13426-04

CG 014928

By

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July 1977

A MODEL TRAINING PROGRAM
FOR A NEW CHILD-CARING PROFESSIONAL
FOR
A BROAD SPECTRUM OF SERVICES
IN CHILD MENTAL HEALTH AND EDUCATION:

THE CHILD MENTAL HEALTH SPECIALIST

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It was in the garden of a madhouse that I met a youth with a face, pale and lovely, and full of wonder.

And I sat beside him on the bench, and I said "Why are you here?"

And he looked at me in astonishment and he said, "It is an unseemly question, yet I will answer you." . . . "Each (father, mother, teacher) would have me but a reflection of his own face in the mirror."
"Therefore I came to this place. I found it more sane here. At least I can be myself."

Then all of a sudden he turned to me and he said, "But, tell me, were you also driven to this place by education and good counsel?" And I answered, "No, I am a visitor."

Then he said, "Oh, you are one of those who live in the madhouse on the other side of the wall!"

—Kahlil Gibran

Kahlil Gibran, "The Mad Man," The Wanderer. New York: Alfred A. Knopf, 1932, p. 42 f.

FOREWORD

It is difficult to pinpoint the origin of an idea. It is seldom an intellectual process in the beginning, although it ends up as such. In the present case, it was a gut experience to begin with, and only later became an intellectual process.

When dealing with children, one has the opportunity to view them in a total spectrum of their wants and needs, their behavior, their care and management. As a result of these professional experiences, what has become most outstanding in my mind is a gross neglect and disservice children have been receiving throughout history and are still receiving today. Such neglect seems particularly embarrassing to this country with all its technology and intellectual know-how.

With this realization of child neglect came the formation of a concept that could, if carried out, revolutionalize our services to children in general, and disabled children in particular.

That was over two decades ago. Today, it is possible to say that a major step in this direction has been taken via the Child Mental Health Specialist Training Program.

The following report attempts to show, in some detail, the program in all its aspects: from its inception, through its developmental stages, to its current operation. It will also be shown why the need for such a program has become so crucial that it warrants the painstaking efforts of all those involved to guarantee its success and credibility.

It is not often one has the opportunity to be part of the total development of an original concept and its development into a viable and credible solution to a problem that is reaching crisis proportions. When such an opportunity has been experienced,

as in the present case, it gives one not only a feeling of humility and gratitude, but a certain sense of urgency to ensure that it continues to grow and develop into a full-fledged program that will benefit this country's children so desperately in need of its services.

CHILD CARING

THE PAST

A HISTORICAL PERSPECTIVE OF CHILD-REARING AND CHILD-CARE PATTERNS

A search into the literature of the past for child-rearing practices over the ages shows that until the present century child rearing simply has not been a critical issue. Indeed, prior to Montessori, Froebel, Susan Isaacs and the Freudians generally, it was not the type of advice given on child rearing that was outstanding. It was that so little advice was given at all. The reason for this was that until the present century the dominant issue in child rearing has been simple physical survival. It is peculiar to this century and only to those technologically advanced countries where infant and child mortality rates have been reduced to comparatively insignificant proportions that child care takes on any importance. The early approach to child rearing is described in the Bible which gives a number of examples of the utter contempt early mankind had for the child as an individual. Many instances are described of cruelty to children, often times offering them up as sacrifices. In addition, the average child of the times was expected to carry out duties far beyond his years.

In later ages a different attitude towards children developed, particularly among Hebrews (1). They showed more awareness of individual differences, especially in the area of education.

The literature shows, however, that a more progressive and human attitude did not develop uniformly throughout the various cultures (2).

For instance, a different approach to child rearing from that of the Hebrews developed in Ancient Greece (3). In this culture the process of growth from childhood to manhood was seen as requiring special approaches to facilitate and improve that growth. There was still a complete disregard for children, because if the father or state did not approve of the child's condition, the child was subject to death by exposure. Mother-child relationships were of no consequence. Throughout its development, the child never knew its mother in any close relationship necessary for security. The child as an individual himself received very little attention or consideration.

It is interesting to note that child rearing and care patterns are closely bound to cultural mores. For instance, in Ancient Greece two cultures, Spartan and Athenian, lived side by side, each with distinct child-rearing patterns (4). The core of the Spartan society was militaristic; all things were rigid and subordinated. If the child was permitted to live, he was treated harshly so that he would be prepared to be tough in wars. Physical hardship was the ideal. Children received little intellectual education. Boys at the age of seven lived in barracks while girls remained at home. The emotional development of anyone at the time did not go beyond an immature homosexual level.

In contrast, the Athenian child was trained for peace rather than war. A well-rounded education was considered most useful to the state. In this culture the child was provided ample opportunity for cultural training and broader character development. The art of the times depicts children as healthy, cheerful, and active, although somewhat lacking in individual character. Here, also, boys were sent off at the age of seven. Instead of to military training and war, however, they were sent to school under complete charge of a slave. In neither culture, therefore, were parent-child relations of any consequence.

A different picture of child rearing had emerged in Ancient Rome (5). The family of Ancient Rome was patriarchal par excellence. It is at this time that we see the emergence of the family as it is today, although its organizational structure was more religious than social. Infanticide, on the other hand, was still practiced, but not as much. Corporal punishment also was on the decline. The child was considered the property of his father while the mother was responsible for the care and education. The child was not considered a slave of the state, which marked an advance over practices in Ancient Greece.

Unfortunately, this relatively "advanced" approach to child rearing did not spread throughout Europe during the Middle Ages (A.D. 476-1500). The destiny of the child throughout this period was particularly bleak (6). Until the 12th century, Medieval art depicted children physically as small adults. The idea of childhood simply did not exist in Medieval society. As soon as a child was toilet trained, he belonged to adult society. But since he was too fragile to take part as an adult, he just "did not count." The Middle Ages were times of superstition and religiosity. The child always was the victim of the concept of original sin. Guilt and responsibility fell on the child, not on the parents. Destruction at birth, abandonment, and falling victim to witchcraft were the common lot for many children. In fact, it was common practice for witches to actually eat children at certain cannibalistic religious acts (7).

A child's life was not worth much during this time period. They were used as pawns. Often they were offered to monasteries and convents around the ages from four to seven. Sometimes they were doomed to serfdom regardless of their parentage (8). Infant and child mortality rates were very high, but perhaps the child lacked the will to live in such times.

The more enlightened approach in Ancient Rome carried over into the Italian Renaissance (9). It was during this period that we finally see the mother being recognized as an important foundation in the life of the child. Education was broader and made more attractive to the child. It was liberal and extensive, yet the need of the child to relax and enjoy himself was not overlooked. Corporal punishment was condemned.

The English Renaissance, on the other hand, does not present the same picture (10). The general attitudes of the Middle Ages towards children persisted. The atmosphere of the home was not conducive to warm relationships. Strict obedience was expected at all times. Superstition was still rampant. Child sacrifice was still practiced. Hordes of young delinquents roamed the streets--a situation which worsened during the 17th and 18th centuries.

During the Renaissance period in France we see literary and artistic brilliance coexisting with barbarism. Montaigne (11) saw the early years of the child's life as the building of the personality. He advocated affection from the parents and held that education would be better achieved through a gentle approach. In practice, however, Montaigne was pretty much ignored. Children were still abused and misused and left to fend for themselves. If there was any thought of children as amusing or agreeable, this was promptly brought to a halt in the 17th century by the moralists and pedagogues who touted the serious and realistic concepts of childhood which emphasized strictness.

In colonial American the same lack of sensitivity to the child's emotional life existed (12). There was a tendency to curb any amusement as a dangerous obstacle to salvation. Complete obedience and submissiveness on the part of the child was expected.

Strict rules were layed down for his behavior. However, by comparison with Western Europe, parent-child relationships were much closer with the child being the object of much concern.

It is not surprising that the oppressive child-rearing practices of the Middle Ages in Europe persisted into the 17th century. In this century the emotional life of children was still oppressive, inhibiting, and often cruel (13). The parents' lack of awareness of a child's sensitivity to traumatic experiences is evidenced by the common practice of the day of family visits to an "insane asylum" as a form of entertainment, something akin to a modern-day visit to a zoo.

It is only in the 18th century that a slow turning point begins in Europe, especially in France. Due to the high proportion of illegitimate births and child abandonments, the state was forced to take severe measures to protect the child. Thus, we see the first enactment of laws for the protection of the child (14). This protection, however, did not include safeguards for the child's life. These were only established during the French Revolution.

A different picture existed in England where the child was considered more of a useful implement for economic and practical necessities (15). Infant mortality was rampant in both England and Wales in the 19th century. The child was neglected for a variety of reasons, and little or no protection was afforded him. The magnitude of child employment became a major factor due to the development of industry. In early 19th century England, children were sent to work in mines as early as the age of five. They were harshly treated and physically abused (16).

In France, on the other hand, discipline was softened and corporal punishment prohibited (17). Education was compulsory. The importance of the mother figure was

heightened and realized. The small size of the families fostered overindulgence with children.

In America at this time, compactness, family unity, and efforts to understand the needs of children in the pioneer family were more evidenced than in Western Europe (18). Concerns about child rearing increased during the 20th century. A new school of thought developed directed by the psychoanalysts and nursery educationalists of the time. This school held a basic interest in the child's natural emotional and social development. That, plus a less inhibited approach to sexual function, led to a greater permissiveness generally. Susan Isaacs was promoting more time for play and companionship. "At last the dirty, noisy child could be accepted as a good child" (19).

Gradually the concept that close human contact was necessary in child rearing began to prevail. In England, James Robertson, from the Tavistock Clinic, started a campaign to persuade children's hospital wards to admit mothers with their children, or at least not to restrict their visiting. The Platt Report (20), published in 1959, recommended that all hospitals not restrict such visitations, that "it is particularly valuable for the mother to be able to stay in hospital with her child during the first day or two," and that children shouldn't be admitted to a hospital at all if it could be avoided. Anna Freud (20) stressed the emotional difficulty of small children separated from their mothers. "Clearly," observed the Newsons, it became obvious that "cuddling is not only nice but necessary" (21).

Parents desired to be <u>friends</u> with their children; they regretted the authoritarian relationship they had with their parents and took pride in the new feeling of equality

between themselves and their children. At the same time, parents became "conscious of the complexity of their responsibilities and of the splendor of their rewards" (22).

We see, then, a gradual change over the ages in the attitude towards child rearing from a harsh, barbaric to a more physical and attitudinal humane approach. How these attitudes are reflected in our approach to contemporary child care is described in the following section.

The English Model - Residential Social Worker

In England, problem children are looked after in a type of residential treatment home or boarding school. The composition of staff in these schools or homes includes residential social workers, teachers, social care workers, psychologists, and occasionally full-time psychiatrists. Only about 13 percent of the residential child care staff have been professionally trained.

Residential child care training in England may take many forms: There is a professional full-time, one-year course; an advanced course of an additional year; professional part-time courses taking two years; in-service, nonqualifying courses of varying lengths; and preliminary training for two years for young people just finishing school.

Because of the scarcity of trained residential workers and a lack of uniformity of training of the limited number of trained people, the British Central Council for education and training in social work set up a working party in 1972 to review the existing pattern of training for residential work. They also were to consider the levels of training needed, and to develop specific proposals for a schedule of training in

residential social work (23). The British Council determined that only 4 percent of the staff caring for 395,000 people in residential institutions had an appropriate training. As a result, they were concerned about the future of training for residential social workers for both adult and children services. In view of the fact that residential services made up a significant proportion of social services provided, the Council decided that residential social workers should receive training equivalent to that of field social workers and that they should receive a common qualification. Although the Council had not yet determined of what that training should consist, they had decided that there should be more than one level of training and award in social work. It was clear from current practices in residential social work that there was a great need to improve both the services offered and the status of residential work if the best possible people were to be attracted to this profession.

The justice and psychiatric fields felt that the residential provision list should be amended (24). They argued that residential care is separate from field social work and, therefore, requires a separate pattern of training. Others felt that a distinction between welfare work and social work was devisive and a specialization in institutional care an unnecessary hierarchical structure.

Evaluating the various opinions, the task force concluded that residential centers needed to involve themselves with the total needs of the individuals, whether adult or child, including spiritual, emotional, physical, social, and educational aspects. These needs, they felt, could not be met by one person alone. Residential social work, therefore, should be multidimensional in its range of relationships and methods of intervention. As a result, the area of residential social work demands skills equal to those of other

areas of social work. In order to insure a uniform approach in service proficiency, the task force stressed the need for a uniform pattern of identical learning programs wherever residential social workers would be trained. They proposed that residential social work should rely extensively on nonverbal methods of communication such as skills of homemaking, bathing or feeding, and various other planned activities. An understanding of, and insight into the more specialized aspects of residential care would be gained through supervised practical work.

The tasks and skills required of the residential social worker would mean producing more than mere technicians with precisely defined capabilities. However, activities would still be ennumerated under the heading of social work, the provision of personal services, personnel management, administration, forward planning, student training, and other functions. In addition to these basic skills, the residential worker also needs the skills of a hotelier, nurse, teacher, and occupational and physiotherapist. Many of the necessary skills cannot be transmitted in formal learning situations but can only be acquired through a supervised experience in a residential setting. The task force determined that the total training necessary would require at least two years of full-time study and practical work. They also suggested that all social workers be trained according to the same training structure and see themselves as members of a common profession with common goals and working methods.

The task force recommended one year's full-time, college-based academic training plus an additional year of work experience. They realized, however, that it is difficult to define academic course work in terms of time, since it really is a matter of a unit of completed work regardless of how long it takes to complete.

The task force also realized that although the establishment of a formal structured program consisting of both academic and applied training would be costly, the needs for such a program more than warrant such expenditures.

Continental Child Care Models

In 1974, two years after the task force of the British Central Council for Education and Training in Social Work had brought in their recommendations for the training of residential workers, the Ninth European Conference on Residential Child Care Training (25) published a report overviewing the types of child care workers in their respective training programs throughout most of Western Europe. A conference was held which lasted a considerable period of time but which, unfortunately, produced very little written material. Participants of this conference included members of the child care professions from Denmark, Norway, England, Germany, and French Switzerland.

The overall conclusion of the conference was that the education of the social "pedagogue" or "educateur," as they are called, was remarkably similar in the participating countries. Most include the subjects of law, politics, administration, social medicine, psychology, psychiatry, pedagogics, sociology, crafts, drama, music, gymnastics, social methods, and child casework. It was felt, however, that throughout all these courses too much emphasis was placed on theory in relation to methods of child care. Students needed to develop a greater sensitivity in interpersonal relationships.

The Danish Model

The Danes look upon their various social services as a normal kind of service such as those which are commonly provided in schools or hospitals (26). The theoretical content of the training in the social fields is modest as compared to the educational field. As a whole, the emphasis is more pedagogic than therapeutic.

The training varies from a few months to two years and has varying entrance requirements. It is considered that the level of training in day care institutions and residential care is relatively good. The staff is lacking, however, in training in the social field, especially in work with the aged.

There are two groups of social workers in Denmark--social pedagogues, who provide direct care for the clients, and the social "formidterne," who arranges assistance for the client including financial aid, housing, etc. Although there are significant overlaps, the distinctions are practical.

There are nine different training programs for the social pedagogue in Denmark plus a number of shorter courses. It was found, however, that at least 50 percent of the training is the same and that all are geared for comparable work.

The Ninth Conference on Residential Child Care Training proposed that instead of this variety of training, a common training program be devised which would be three years in duration including one year of practice. The ultimate aim would be to make this program equivalent to primary school teachers' training in duration. The first year would be common to all and would provide a basic knowledge in education, psychology, social sciences, law, activities, and so on. In the second year many of the subjects would be the same except that students would choose an age level at which they would

like to work (preschool, school age, adults, or aged). The third year also would have common course work, but there would be specialization in the type of clients (kindergarten, mentally deficient, handicapped, etc.).

Unfortunately, the Danish Ministry of Education has not been too cooperative with this proposed program. Their emphasis is on teaching and on the management of all normal children from ages two to the end of the school years. The Ministry basically is not interested in training for special client groups. Cooperation with the Danish universities also has proved to be difficult until now because they are not geared towards an adequate level of administrative training.

Norway

The picture in Norway is quite different from that in Denmark (37). Psychiatric treatment homes in Norway for children and young people are financially covered by the same insurance system. Consequently, it is felt that the overall medical coverage is good, but that there is not enough available for the psychiatric level. There are three main types of institutions for children in Norway: 1) Homes for normal children which admit youngsters from one to eighteen years of age. These homes rarely need to admit children because of poverty. Most often they are placed in these homes because of a death or illness of one or both parents. 2) Special boarding schools for mentally deficient, deaf and/or blind children. Due to the recent increase in small external schools in Norway, these special boarding schools have been confined mostly to admitting residents with more severe problems. 3) Psychiatric treatment homes which emphasize the development of theories about residential living.

The trends in residential care development in Norway are to try to keep children in their own homes, to work with the whole family, and to increase the number of institutions for the "hard-to-reach" youth (28).

As elsewhere, major problems of youth in Norway are all related to educational, psychological, or social problems. There is a great lack of trained persons to deal with these problems. The training of child care workers in Norway occurs at two levels.

The first is a short-time training program of six months to one year for the training of nurses who deal mostly with the care of infants. The context of these courses differs depending on where they are taught.

The second level of training child care workers in Norway is a two-year training program. There are two schools which offer this training. In addition to this, there also is a three-year program for people working with the mentally disturbed. It has been proposed that these two levels be combined into one three-year social pedagogy program.

The child care worker concept in Norway is that of a new and rapidly developing vocational group. Great emphasis is put on fieldwork placement. The rules for admittance to the training programs are that the applicants be at least nineteen years old, have passed their grade nine equivalent, and have worked in a residential setting for a minimum of one year. The lack of qualifications in one area may be substituted for outstanding qualifications in another. The training is aimed at developing vocational attitudes, theoretical knowledge, and practical ability, and the skill to apply this knowledge. The curriculum consists of psychology, pedagogy, civics, hygiene, residential work, child welfare, creative activities, and general education (29).

To become a social worker rather than a child care worker in Norway, one must pass the university entrance examination and be interviewed by a social worker or a psychologist, then take a three-year training program. This training is divided into three main groups: 1) Methods subjects which include casework, social group work, social planning and administration, and the planning of community work. 2) Basic subjects which include psychology, sociology, social economics, social medicine, state and municipal affairs, law, criminology and penal law, psychiatry, mental hygiene, and social politics. 3) Other subjects which include statistics, teamwork, excursions, and project papers (30).

West Germany

A somewhat similar process as that in Norway has been developed in Germany for residential workers (31). Here, three different training programs were developed which consist of: 1) An occupational school for social pedagogists. 2) An occupational high school for pedagogy and social work. 3) High school and university training in pedagogy.

The first type of school provides a three-year program. The first two years consist of mostly theoretical work with four to eight weeks of practice while the third year has a full-time probationary work period in an institution under supervision. The second type of school is a preparation for a job which demands utilizing scientific statements. To qualify, a student must have passed his third year in high school. The training lasts four years or eight semesters in Baden-Wuerttemberg and in Bavaria, and six semesters with a probationary year in all other parts of West Germany. The Baden-Wuerttemberg model is considered the best. The first three course terms consist of basic

training, the next three terms of theory but not yet specializing in any particular area. Subjects include pedagogics, psychology, politics, law, social medicine, and science. The fourth term consists of practical experience to help in the choice of a specialty. The next five to eight terms are the specializing terms with three terms of theory and one of practice. During the fifth year the student chooses his special area and prepares for it. The areas for specialization include preschool training, residential training, youth care work, adult education, criminal pedagogics, and social administration. To complete the training, the student must write a thesis and pass a written and oral examination. He then receives an academic degree and becomes a social worker.

The third program includes training in social pedagogics and includes ten to twelve terms, although one may pass with only four terms. It appears that the total twelve terms of this program can be likened to our type of teacher training.

The Spanish Model - Educateurs

The Spanish model for training child care personnel is quite different from the German model (32). The emphasis of the Spanish model is to try to make "educateurs" of persons already working as teachers. This emphasis has come about because of the poor training, working conditions, and prestige generally afforded the "old" type of educateur.

In order to upgrade the child care profession, a training center was set up in Barcelona. Although the center is a private institution financed by the Ministry of Labor, a government department concerned with child welfare, the students themselves, and various private organizations, it operates within the framework of the University

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of Barcelona. Notwithstanding this university affiliation, the diploma is not recognized by the Ministry of Education and Science and, therefore, carries no administrative value.

It is interesting to note that in contrast to other models in other countries, the proportion of women in the Spanish program is much greater than men. This appears to be largely due to the cultural attitudes towards the type of work involved, the poor pay, and the lack of prestige of the profession. The program itself has no rigid entrance qualifications. The center calls for a "bachillerata" as a prerequisite, which is a preuniversity degree. The majority of the students do not have this but have satisfied a "cultural equivalent," which has no academic translation, but usually means having a diploma and experience as teachers. The applicants have to be at least eighteen years of age.

The emphasis of the program is on mentally retarded children, again as a result of the official and cultural bias towards this type of problem. Other problems, regardless of their severity, seem to be taboo areas in the Spanish social structure and are, therefore, de-emphasized. The program lasts two to three years but only on a part-time basis, mostly Friday evenings and Saturdays from November to June. Students, therefore, have the opportunity to continue their full-time employment, generally as teachers. They are selected on the basis of their motivation, their capacity for logical thinking, their psychological balance, and their ability to establish human relations.

The program is divided into three basic parts: basic theoretical knowledge, clinical experience and application; and techniques of expression and communication.

The program at the center differs from other pedagogic phychological, or sociological courses in that there is:

-an evaluation of day-by-day living situations in which children find themselves

-a psycho-diagnostic orientation in relation to psycho-pedagogic work

-using the student group and their lives as a learning tool

-reflecting on the daily work lives of the students in relation to the growth of their personalities

-an adult orientation and approach which is more common sense than academic

-the development of a critical outlook on theoretical information

-an objective approach to social work which is aimed at removing old myths, ambiguities, and contradictions.

Another interesting feature of the Spanish program is the evaluation of a student's performance and his understanding of the academic material. These are made on a continuous basis rather than in one final examination. A final assessment is made by synthesizing all of the previous partial evaluation of the student's work along with a presentation by the student on a subject of his choice. The latter must consist of original work and be based on personal experience.

The French Model - The "Educateur Specialisé"

The concern which the French showed for the welfare and rights of children in the 1800's is continued in the 20th century. The French were probably the first to extensively develop the training of child care workers as "educateurs specialisés" which occurred in France in the 1950's (33). The training program developed as an independent discipline and not as part of either education, social work, or psychology. The success of this development is evident in the fact that at present there are some twenty-six

training colleges which train yearly about three thousand to four thousand educateurs specialisés (34).

Entrance requirements to the "educateurs specialisés" program is comparable to the American junior college degree. The actual training program lasts for three years. About 50 percent of this time is devoted to internships in a variety of treatment centers; another 25 percent of the time is concerned with craft and vocational training, while the remaining 25 percent of the training is given over to actual academic course work and thesis writing. One of the three years of training places maximum emphasis on group living including guided group interaction and sensitivity training.

The French educateurs are highly trained youth workers. They are concerned with the total life process of their charges rather than with just one or two specialized aspects. The recruitment and training emphasizes positive and normative aspects of adult and child behavior. The educateurs are expected to serve as a model for the child to emulate, and they are trained to program the entire daily and weekly life of their charges. The emphasis on a "normal" personality is augmented with the use of various crafts and skills as tools for the resocialization of the children. In institutional settings, the French "educateur specialisé" completely structures all the nonschool hours of the children. He is the central person in their lives. Because of this, a therapeutic relationship is developed which is based on the modelling behavior of the child in which the child gains insight into his behavior by what the educateur does rather than says. Thus, the main assumption is that the adult closest to the children is, in fact, the most important change agent for reeducation and resocialization.

The major components taken into consideration in the French child mental health model include behavior modification and social learning theory, and social and cultural factors evident in the behavior of children.

An interesting aspect of the French model is concerned with juvenile delinquency. The French believe that major emphasis should be placed on careful behavioral observation and diagnosis prior to court sentencing or institutional placement. This observation and diagnosis, along with extensive case evaluation, is done by the educateur. He is requested by the court or child welfare agency to observe the child's behavior in an open setting rather than an observational center for the obvious reasons that the center is an unnatural and restricted environment for the child.

Upon graduation, the "educateur specialisé" may seek employment in, and possibly ultimately manage institutions for delinquents, retarded, physically handicapped, socially and emotionally disturbed, the homeless and neglected, unwed mothers, and any kind of agency setting concerning children.

The Canadian Model - The Psycho-Educateur
(The Specialized Educateur of French Canada)

The French educateur specialisé model for training professional youth workers was adopted in French Canada. An extensive discussion of the aims of the training program has been provided by Dr. Michel LeMay (35). It is remarkable what changes have taken place in some places in the field of child care. It is equally remarkable that whereas some countries adopt a uniform pattern of child care and training of child care professionals, other countries do not. In fact, many countries only have localized training programs, if any. The specialized educateur training in French Canada

combines aspects of the psychologist, social worker, and teacher. He is a psychologist in that he tries to understand child behavior. He is like a social worker in that he adapts his knowledge of social problems to the needs of the child's environment and the interrelationships which develop in that environment. He is like a teacher in being concerned with such problems as discipline, regulations, and the acquisition of habits as he teaches his children the "art of living." In addition, the specialized educateur is a specialist in leisure-time activities. And, finally, he is a parent substitute who must recognize, control, and utilize as much as possible such problems as transference inherent in such a role.

Perhaps the most distinctive feature of the "educateur" is that, in all his roles, he lives with the children and must interact with them in all their daily activities. The therapeutic possibilities thus available to him require of him certain essential attitudes. Fritz Redl and David Wineman have described some of these (36). They include:

-intentional lack of awareness

-physical proximity and control by touching

-greater show of affection

-assistance at opportune moments

-regrouping

-direct appeal

-removal of the child in certain situations

-formal permission and refusal

-threats and punishments

-intervention whenever appropriate

-emotive participation or interest shown in what the child is doing

-relief of tension by humor

-interpretation as intervention

-reorganization of an activity

-restrictions in the use of space and objects

-physical restraint

-promises and rewards

The educateur is trained to use various techniques of interchange in order to enable the child to have an "apprenticeship" in more suitable relationships with those he is in close proximity to on a day-by-day basis. The educateur-child relationship is "managed" by making use of the transference phenomenon. The transference provides an opportunity for the child to relive emotions and anxieties which rise not from the immediate situation but from former object relationships. To derive the most benefit from such situations, the therapist in this case--the specialized educateur--must adopt a certain number of attitudes based essentially on one of benevolent neutrality and on the deliberate control of the relationship. In order to show up the contradiction between the child's ideas and his emotional reactions, the educateur plays none of the roles being transferred upon him by the child. Unlike the psychotherapist, however, the educateur does not center his relationship with the child on this phenomenon of transference. Indeed, he acts directly on the child's ego by utilizing daily events. One of the factors often lacking in the environment of a maladjusted child is the identification with an adult which also includes feelings of being loved and accepted and the encouragement to make his own values and standards.

Other factors which are missing in the socially maladjusted child's environment include opportunities to benefit from worthwhile recreation, opportunities to establish ties with a community other than his parents, a nondisintegrating family structure, and an economic security for basic needs. These factors directly influence the child's conduct and the evolvement of his relationships. Thus, the educateur must engage simultaneously in individual and group work. To do so he must have certain fundamental skills. These include a sympathetic attitude for establishing a friendly and trusting

atmosphere. This means that the specialized educateur has to use his intelligence; he must be sensitive, have a capacity to empathize and be able to show controlled emotion. He must have tact and a feeling for nuances. He must be cautious in knowing which topics will not be destructive to the strength of the child's ego; and, of course, he must be capable of being an attentive listener in order to permit real expression on the part of the child and to avoid making hasty conclusions.

One very specific aspect of the specialized educateur's profession is the ability to know, recognize, and utilize certain behaviors or actions right at the moment it emerges during the course of daily life with the child. The overall responsibilities of the educateur living on a daily basis with "his" children are varied. Some may seem very minor and thus run the risk of having their fundamental importance overlooked and therefore forgotten. Such responsibilities might include sleeping in a dormitory or supervision of the cleanliness of bodies and clothing, which directly attain to the acquisition of social practices. In his reeducative role, the specialized educateur must be a game player. He must lead profoundly disturbed children towards a level of maturity sufficient to permit them a certain degree of autonomy. However, since these goals of child care are not established on a hierarchical basis but rather intertwined to make up a whole, it is difficult to precisely define the role of the specialized educateur.

One dangerous aspect of the role is that it places the educateur in situations which can reactivate old conflicts which stem from his own infancy. This can be seen in the high frequency of resignation among educateurs. These resignations are not so much due to the frequently exhausting pattern of work, overloaded schedules, insufficient

lodging, etc., but are more the consequence of emotional conflicts too intense to be tolerated.

There is also the painful impression of not always arriving at one's goals. The educateur, like anyone else, hopes to get part of his motivation from satisfactions experienced in the course of his work; but reactions of maladjusted children are difficult to foresee.

Fatigue is a very real factor in the profession of the specialized educateur. A succession of things, relatively minor in themselves, can cause the educateur to become very sensitive and on edge, therefore running the risk of interferring with his work. Often a particular failure with a particular child who seems to progress satisfactorily with another staff member may hurt him and could in turn cause the educateur to turn on his colleagues in an aggressive fashion.

Nevertheless, the teamwork that exists around the specialized educateur system is one of the things contributing to its richness. It serves as a meeting ground of various specialists (technical educateurs, educateurs, specialized teachers, social assistance, psychologists, psychiatrists, etc.) all of whom have clearly defined areas of activities yet inevitably overlap, thus providing a vital sort of check and balance system.

The teamwork existing in the specialized educateur system did not occur by chance. Team members must share:

-a conception along the general laws of development of the human being

-efforts to understand reciprocal work goals and fundamentals

-recognition of the necessity for leadership

-a common conception of work

-a genuine respect for other professions, even though collaboration may often prove difficult

-a certain common training

-a common emotional "in tuneness" with this common activity

-common support for the general concept, while also recognizing the difficulties

The specialized educateur should not be confused with the medical assistant, the psychological aide, the leisure time counsellor, or a kind of social worker. His functions are unique and original to the degree that he has been trained.

The French Canadian school for educateurs bases its training on four general principals:

1. A basic education in child psychology, pedagogy, sociology, psychopathology, anatomy, psychology and law
2. A basic education in methodology given by those who know it "from the inside"
3. An education in educative techniques including physical education, directed activities, expression, games, etc.
4. Periods of sponsorship by graduate educateurs, case studies, case discussions, supervision, seminars, projects and psychological sessions, all aimed at assuring continued integration of theory and practice

The educateur of maladjusted children must be able to satisfactorily draw upon a study of the child's psychology including motor, intellectual, affective and social development, biology including physical development of the human being, the relationship between soma and psyche and pedagogy, and a knowledge of the general history of pedagogy and its practical applications.

The educateur must be able to make an analysis of the child's behavior based on important ego functions. He must be able to place a particular child's personality in its relationship to its socioeconomic contacts which necessitates a general knowledge of ideas of groups in microcosm, living conditions, experiences, etc. The educateur must

be able to place the child's personality in relationship to anomalies, which necessitates a general knowledge of psychopathology.

He must be able to modify the child's behavior through individual assistance, utilization of the treatment program, through the management of the group, through the utilization of the environment, and be able to organize a life schedule adapted to the needs of the child.

Knowledge and skills are not acquired instantaneously. A gradual integration of these are acquired only through daily practice, through probationary periods, case studies, case discussions, teamwork, supervision, and by end-of-year examinations, etc. All this knowledge and skill is taught in the framework of "humaneness," humanism, spiritual values, professional ethics, and basic knowledge of the legal rights of children as well as the administration and management of services and institutions provided by various governmental departments.

Child Care in the United States

The Child in an Adult-Oriented World

As was discussed in the first section, child-raising practices are very much the result of how the child is being viewed in our society. Notwithstanding the lip service we are paying to children's rights, somehow in the evolutionary course of American society, the shortsighted view that all major rights, privileges and services should go to adults first and to children second has come to prevail.

The democratic concept that all human beings should enjoy equal rights and opportunities under law does not yet apply to children. Due to modern civil rights

legislation we can now say that all men and women in our society, regardless of race, creed, or color, are equal in the eyes of the law, provided they are adults. The child in American society does not yet enjoy the same rights.

"Wait until he grows up" seems to be the common American attitude regarding children. The fact that this attitude is illogical does not seem to matter. Although we believe that the course of our lives and the future of our nation depend on the level of functioning of the adults in our society, we do not invest in our children as our best and most critically important assets. We seem to believe that some magical transformation will take place the second a child becomes twenty-one years of age. This is not only ludicrous but also dangerous to the future of our society. We cannot afford to wait until children grow up. Until now, American society continuously has accorded child rearing a shockingly low status in our national economy. Child care workers, mothers' helpers, and housekeepers all are at the bottom of the list of earnings by occupations. Regardless of the number of children a mother has to look after, to "raise," she is not considered working unless she is gainfully employed outside the home. It is simply not to our nation's best interest to downgrade child caretaking roles to this degree. There is probably no more difficult or important task than raising children.

As a result of giving such little regard to small children, we are fostering their neglect. This leads from a lack of a sense of family closeness, to feelings of rejection, and to the lack of a sense of self-worth. All these predispose to a social and antisocial behavior prevalent in our society today: drug abuse, stealing, truancy and dropping out of school, sexual exploitation, illegitimate pregnancies, child abuse, and so on.

In addition, giving at least equal consideration to children as to adults is good economics. The cost of providing for an individual child at risk of maldevelopment due to inadequate parental care is approximately two thousand dollars per year for fifteen years, or thirty thousand dollars total (37). Compare this to forty-five hundred dollars to eighty-seven hundred dollars per year for managing a mentally handicapped child, two thousand dollars to nine thousand dollars per year to educate a youth out of delinquency behavior, ten thousand dollars to fifteen thousand dollars per year housing him in a correctional institution or placing him in security care, and twenty thousand dollars per year carrying him as a dependent adult for approximately fifty years (38).

Child care is worthy of top billing in the national hierarchy of priorities, yet an overview of the services and privileges accorded to children shows them as ranking considerably less than adults. According to one critic, services for children have been poorly organized; they fail to assist the children for whom they were designed and are antagonistic to children in that many are coercive in nature (39). He charges that the rights of children in the treatment process over the years have been subordinated to the needs of parents, society, or the treatment clinics themselves. Child guidance clinics are shaped more to suit the needs of the professionals within them than to those of the children being served. Mental retardation, delinquency, and unrecognized psychosis are systematically excluded from the clinic's case loads. Furthermore, Work states, the restorative aspects of family therapy are directed primarily towards the adult and family (40). When children are included in family therapy situations, it is usually because the children are not conforming to the parents' ideas of right and wrong. Right

and wrong is, therefore, translated into clinical concepts of health and unhealth, meaning that if the child is behaving "wrong" in the parent's eyes, then he is behaving "unhealthily." The concept of making a child conform to the expectations of adults is carried over into the residential treatment centers. The two major purposes of such centers have become to rid a disturbed child of his "bad" behavior, and to separate him from the general population so as not to be harmful or visible to others. Institutional rules often deny the disturbed child any contact with his family, or his family may simply abandon him to long-term placement. The children are promised therapy and restoration but in fact are treated for long periods to make them fit into a mold of conformist adult society and are denied release until such time as they are deemed conformist or cured of their nonconformist behavior. This system is also applied in schools with regards to learning problems which, unfortunately, often simply means that the child does not conform to the school's system of learning. In such cases he is "therapeutically" made to fit.

Independence generally is considered an attribute among adults and is highly favored in those with positions of leadership. Signs of independence in children, however, most often cause parents and society to attempt to control and limit the children's activities. Often such limits are repressive in nature with discipline becoming highly coercive and punitive. Thus, controls are set to protect parental rights, and to help fit children into the adult system. The legal rights of children by and large have been ignored.

In our adult-oriented world children are often considered chattels and are barred from the legal rights enjoyed by adults.

In most countries child mental health services are an integral part of child health and welfare programs. The spending of vast amounts of tax monies for these purposes is widely accepted. Quite naturally there is a great amount of responsibility and status accorded to the child care staff in these countries.

As was discussed previously, emotionally disturbed children in need of residential and day care programs are taken care of by professionally trained child care personnel.

In the U.S.S.R. children are cared for professionally, days, evenings, or on a residential basis in clinics which provide all children's services (41). There is a continuity of service to all ages maintained through all levels of care. Health is considered a resource. The continuity of care in Russia also includes provisions for aftercare unlike the United States.

No community in the United States has all facilities for care. The few services available are poorly coordinated and not available to the poor or near poor. We do not train professional child care personnel except in a few isolated instances. There never will be enough properly trained professional personnel in the field to meet the needs unless the nation takes drastic steps to change its priorities.

All children deserve mentally healthy lives where self-direction and satisfying interdependent relationships prevail--lives with meaning, purpose, and opportunity. Unfulfilled lives cost us a loss of human resources. A loss of productivity to society and economic costs of dependency.

Every infant must be granted the right to be wanted, to be born healthy, to live in a healthy environment, to have the satisfaction of basic needs, to have continuous loving care and to acquire the intellectual and emotional skills necessary to achieve

independent aspirations, and to cope effectively in our society. Unfortunately, we are far from achieving these goals.

It is estimated that 8 percent to 10 percent of all children are afflicted with emotional problems (neurosis, psychosis, etc.) and in need of special services (42). However, only 5 percent to 7 percent of those in need are getting it. More than 10 million persons under age twenty-five need some kind of knowledgeable help. An additional 2.5 million need help with behavior disorders (43). On the whole, we do far better for the physically handicapped than the mentally and emotionally handicapped.

Emotionally disturbed children have as much right as others to a full life with all the day-by-day things that make it up--love, comradeship, work, play, laughter and tears.

Experiences of professionals working with children indicate that the roots of mental illness and severe emotional problems extend far back into infancy and early childhood. Consequently, the best time for intervention is during the mother's pregnancy and the early infancy of the child.

The Joint Commission on Mental Health of Children (44) has made several interesting observations regarding American attitudes and priorities concerning children. Some of these are:

-The U.S. has no unified commitment to its children and youth,

-We give no real help to child rearing until the child is in need,

-Discontent, apathy, and violence serve as warnings that society has been irresponsible in these ways,

-Psychiatry still centers on treating rather than preventing mental illness,

-There is little effort at developing community settings to keep children in normal routine settings,

-Our young do not receive consistent emotionally satisfying care,

-Society does little to help parents,

-Treatment of mentally ill children today is uncertain, variable, and inadequate,

-Not a single community in this country provides an acceptable standard of services for mentally ill children,

-Training schools provide poorer treatment than caged animals or adult convicts. Children in residence in them are trained in crime,

-We have the knowledge and the money to provide adequate preventative services, but we lack the commitment. For example, we know that it is more fruitful to prevent damage than to heal wounds. Much damage can be avoided in the first three years of life. The basis for mental development and competence is established by age six.

Fostering the development of human beings is a means to an end. We need a coordinated network of services based on total needs of the child as he develops from conception to adulthood. We need an advocacy system for children, such as an advisory council on children similar to the council of economic advisors. Above all, we need an institute of child care which researches effective methods of treatment and rehabilitation and child care, and packages and "markets" this material for distribution both to agencies dealing with children and the general public.

A nation can be of no higher quality than its people; and in this country there is a frantic race by most of us to escape the fear of loneliness, boredom, physical ugliness and human misery of the blighted areas of our cities and sprawling suburbs.

We are the richest of nations, yet we have fallen behind most other industrial countries in programs for children and families. Other countries have recognized what we have not, namely, that life begins before birth, that life is what it has been made from that point on.

A child's mental health depends upon the many societies and systems which make up his life, on the function of his body, the state of his physical health, the health and well-being of his family, and the kind of home, neighborhood and community in which he lives. A child's mental health is determined by all that goes into his existence. Mental illness and emotional disorder have many causes, likewise mental health. To promote mental health we must concern ourselves with all its aspects.

A mentally healthy person continues to grow, based on earlier strength. If a person as a youth is denied opportunities to participate in decisions, he is not equipped to participate as an adult. If he is handicapped by physical, social, educational, or economic adversities, he may become mentally ill or emotionally disturbed. We must rationally and determinately restructure our approach to child care so that it does not cause or perpetuate emotional or behavioral disorders. We can no longer afford to leave change to chance and the same kind of slow development as has taken place in the past centuries. With the geometric growth in knowledge and complexity of living, we no longer can afford only to give lip service to the notion that child care starts at birth and yet not provide the investment necessary in services, organization, coordination, and development of child mental health manpower at many levels of skills.

According to the Joint Commission on Child Mental Health, manpower utilization in mental health professions serving children should be directed at problems of

adaptation (45). Thus, a goal of "positive enabling" directed at helping children to develop creativity in bringing benevolent social change would be indicated. A readiness must be developed to look at new ways of problem solving, especially in this rapidly changing technological world. The concept of "self" must be flexible enough to include levels of existence within the total life span. Services should include prevention, early intervention, crisis intervention, long-term treatment, and rehabilitation programs.

Services can be administered through such programs as screening, consultation and referral centers, preschool home training, special day school programs, adolescent and young adult rehabilitation centers, etc.

A preschool home training program could be provided by public and volunteer agencies for disturbed children. A team of education and other specialists would work with the child and its parents and would provide group guidance centers for the parents. Emphasis would center on early identification and intervention to help reduce severity of mental and emotional disorders. Without this, what may have been manageable can soon become unmanageable.

Children should not be forced to go to a hospital until every available alternative has been investigated. Children's needs and adult needs should not be met by the same service. Children's services should be separate and should not be regarded as a therapeutic agent for adults.

Primary prevention, as we speak of it here, means reducing the risks of mental disorder in a population by lessening harmful influences or increasing people's capacity to master stress in healthy ways. A mental disorder is an unhealthy adjustment to burdens

in the physical, psychological, or social sphere. Mental health requires the provision of adequate physical or social opportunities.

According to Eli Bower in The Protection and Promotion of Mental Health in Schools (46), "Primary prevention of mental and emotional disorders is any specific biological, social or psychological intervention which promotes or enhances the mental or emotional robustness or reduces the incidence and prevalence of learning and behavior disorders in a population. In this framework then we would aim preventative programs to persons not yet separated from the general population and hopefully at interventions which are specific enough to be operationally defined and measured."

Goals for primary prevention in the area of child rearing and child care should be to (47):

1. Increase the biological robustness with services of prenatal care, postnatal care, and development problems of early childhood, middle years, and adolescence,
2. Increase its effectiveness to greater numbers of persons in the general population,
3. Decrease excessive or unhealthy stress.

Prevention programs are aimed most effectively at subpopulations at risk. Their cost-benefit ratio is generally twice as great as traditional treatment programs for the more seriously or chronically disturbed child.

A relatively recent development which incorporates prevention is that of the community mental health approach which emphasizes the creation of an environment in which children are able to develop and grow towards increasing social and educational skills and self-esteem. With this approach, children are not segregated into special

therapeutic environments. Rather, mental health services are aimed at minimizing the amount of failure, rejection, and misery that exist in the natural environment of a group of children.

In order to achieve these necessary services we must make provisions for trained manpower. Under our present system the chances of increasing the percentage of psychiatrists are nil. The number of psychologists and psychiatric social workers is increasing, but the demand far outstrips the supply.

The emphasis should be shifted to other sources of personnel. School teachers are in the front line in the perception of problems and the sensitive management of mentally ill children, also, law enforcement and correctional personnel.

The emphasis should be to seek new, different types of professionals as well as new types of paraprofessionals and nonprofessionals. Much of the manpower not usually available (housewives, mothers, unemployed, etc.) could be trained to provide valuable services. Every member of a community has a stake in the mental health of its children. Potentially all members of the community could contribute either through full- or part-time employment or through their roles as parents, neighbors, volunteers, or citizens.

Unfortunately, to date there is not yet a uniform or even comprehensive approach to achieving these goals. The present picture of child care philosophies and practices of child care workers in the United States consists of many facets most of which unfortunately are contradictory towards each other. The professionalization of child care workers is accepted by many but also opposed by those with traditional orientations (48). New careerists advocate nonprofessionalism, while many members of allied disciplines consider child care as subservient to their own roles (49).

The low-current status of child care workers in the United States along with difficult working conditions, low pay, and limited opportunity for advancement are powerful forces for change. They are also closely associated with the concern for quality of care, autonomy and differentiation from other services. The result is a growing recognition that child care must be professionalized (50).

Child care workers are seeking a separate identity from social workers, special educateurs, psychiatric nurses, and the like. The reason for seeking the separate identity is because the child care workers feel that they should draw on the combined insights from these various disciplines but still have the autonomy and power needed, specifically in child care work, to concentrate on their own areas of expertise and not be involved in other tasks as in the other disciplines.

Child care is a complex field which demands a specialization in itself. Professional child care work would not involve private practice, but rather would continue to function in a variety of service settings. They would continue to work in association with but not be subservient to social workers, teachers, nurses, and others working in similar organizational settings. It is the differentiation from other disciplines that is the chief concern of all child care workers, not the segregation from the organization (the care of children) that encompasses them all.

The economic feasibility of adopting a professionally trained child care worker approach is still a critical concern and as yet unresolved. It needs to be clarified along with the possibility of coordinating and making effective the various child care programs now operative but ineffective. It is clear that operationally defined goals are essential.

Currently, most people who deal with children in the United States are untrained, many not having graduated from high school. Their various levels of performance range from brutal and abusive to highly effective. Fortunately, however, in the past years there are increasing numbers of applicants with college degrees. These applicants are often teachers or similar professionals who cannot find employment in their own fields. It would be impossible to replace these two groups with suddenly trained professionals. Rather, it would be necessary to gradually replace them by establishing a systematic method of differentiation of levels of tasks performed. This presents a special challenge requiring creativity and initiative.

The importance of the professionally trained child care worker has been clearly stated often enough. Unfortunately, it has never been actualized.

There are many misconceptions about what will professionalize the child care worker. One is by attributing more respect and higher status. This, however, fails to deal with the central question of role and training. Child care workers work long hours for low pay. For some reason they are perceived as dedicated missionaries who are supposed to work long hours for little monetary compensation. To simply shorten the hours and increase the pay scale also fails to deal with the critical issues. The answer is that items such as status, hours and pay will automatically accrue to a discipline or profession which has its own distinct body of knowledge and method.

In current practice, a child's living situation in the various service centers is continuously being surrounded by an increasing team of specialists--recreation specialists, arts and crafts specialists, group therapy specialists, etc., while the actual living situation itself continues to be staffed by nonspecialists. This sophistication of

specialized tasks has devalued the primary function of care. At present, a child must separate the specialized types of help from his regular daily activities and take different pieces of his problems to different specialists.

The key to change here is the need to formulate concepts for an educative model rather than one which incorporates such peripheral specialists in which the total ingredients of daily living are combined into a service for growth and change. Unless we can integrate the child's total experience in any service setting, we will continue to "service" him with a barrage of specialists in an uncoordinated and unrealistic fashion. The professional child care worker, therefore, must be a specialist in generality. He must be able to digest a social history, analyze results of various tests and evaluations, assess the capacities of his institutions, and synthesize these into a working model of the child and his needs.

It is vitally important to assess the role and functions of the child care professional before designing his training.

The United States needs to adopt an attitude and practice similar to that currently emjoyed by child care specialists in France and Switzerland where he has legal guarantees and national certification, specialized training in universities, colleges, and institutions, adequate pay (paid more than social service workers), professional status, and broad career opportunities.

An experimental program carried on at Carson Valley School in Flower Town, Pennsylvania from 1967 to 1972 has closely approached the European model. There the child care worker was considered as functioning autonomously with children as well as in the areas of administration and supportive services (51). They accepted responsibility

for the overall program, individual counseling, and work with parents. They received a salary equal to public school teachers. The focus of the care was on resolving problems as they occurred rather than scheduling sessions with specialized strangers later. Problems were viewed as issues and stresses of daily living requiring interaction and education. Concentration of the individual and group processes in which staff and children interacted became the emphasis for the new role of the child care worker. Consequently his role became much more complex.

The underlying message from this practice is clear: Staff who work directly with children in a residential setting must be properly trained to develop the needed skills and competencies and be endowed with the necessary authority and decision-making opportunity and power to plan.

From the success of this experiment and the examples provided by the European models, it is clear that the untrained, other directed child care worker of today must be replaced by a multiskilled, multidimensional milieu worker.

CHILD CARING

THE PRESENT

THE PRESENT TRAINING MODEL

The present report is about the implementation of a training program based on a synthesis of the author's twenty-five-year career in child care and the experiences and findings regarding child care in both the United States and elsewhere. The present training model has endeavored to utilize these findings and experiences in the areas of training skilled and effective child care personnel. Thus, it has been the experience from a variety of programs that a successful training program must contain the following general principles (see Table 1):

TABLE 1

Important Aspects of Child Care Personnel Training Programs in Other Countries
- There must be more than one level of training
- There must be a uniform basic approach on a national basis
- The training must be multidimensional in range of relationship and methods of intervention
- The training emphasis must be on dealing with the total needs of the child including psychological, emotional, physical, social, and educational needs
- Fifty percent of the training should be in a wide variety of applied settings
- Treatment should emphasize the structuring of the child's nonschool hours

Experiences also show that a successful and effective training program should include the following key courses (see Table 2):

TABLE 2

Key Courses Which Other Training Programs Found to Be Necessary in Training Child Mental Health Specialists

- nonverbal methods of communication	- homemaking
- planning activities	- bathing
- nursing skills	- feeding
- teacher training	- hotelier skills
- occupational therapy	- law
- physiotherapy	- applied politics
- social medicine	- administration
- psychiatry	- psychology
- social methods	- pedagogics
- crafts	- sociology
- drama	- child welfare
- music	- child casework
- gymnastics	- civics
- residential work	- hygiene
- general education	- creative activities
- social planning	- social group work
- social education	- planning community work

- state and municipal affairs
- statistics
- excursions
- science
- methodology
- youth care work
- criminal pedagogics
- vocational training
- social learning theory
- diagnosis
- games
- criminology
- penal law
- teamwork
- project papers
- child psychology
- physical education
- adult education
- social administration
- behavior modification
- social and cultural factors
- case studies
- case discussions

Child Mental Health Specialist

The question to which this project has addressed itself is how available knowledge about general principles and key courses necessary for training skilled professional child care personnel can be put together into a successful multilevel training program.

It is only by an evaluation of our current approach to child care that we can hope to deal with what has become a very serious national situation. When many researchers, commissions, and task forces, as discussed previously, are talking about 0.6 percent of all children in this country being psychotic, that another 4 percent have emotional problems severe enough to require professional intervention, that another 1.2

percent are brought each year to juvenile courts on petitions of delinquency and neglect, and that another 10 percent have learning difficulties with no specially trained personnel to deal with any of these problems, then we are talking about a serious national situation indeed. Experts in the field generally agree that we can no longer afford to leave this situation to chance to deal with it. Ignoring it won't make it disappear. We must take action now on a national basis. A first step it to actively develop a new profession: a profession conceived not to function in a temporary or transitory manner, but one which evolves with the society it is meant to serve. This is the Child Mental Health Specialist.

By being a Johnny-come-lately, we have the opportunity to look at both the successful and unsuccessful aspects of training programs in other nations. This allows us to utilize these findings in designing a training program for professional child care workers which is uniquely suited to our own needs and which fits in with our own national attitudes about children and child care.

Practices in other nations show that we must develop a well-integrated, emotionally aware professional who has the capacity to deal with the overall dynamics of the child and his world. A Child Mental Health Specialist must be able to work with children and with families at all levels; he or she must be able to provide a model for both children and adults, a model provided not only through professional actions but through personal genuineness and empathy. To do this a Child Mental Health Specialist must acquire a good interdisciplinary clinical and academic background. In addition, the Child Mental Health Specialist must be able to satisfy the need for a constant personal growth and expansion.

The new Child Mental Health Specialist needs to be trained for competency in seven basic areas (see Table 3):

TABLE 3

Basic Areas in Planning Child Mental Health Specialists

1. Science of education
2. Science of communication
3. Life sciences, including developmental physiology, biochemistry, functional central nervous system, etc.
4. Psychological sciences
5. Clinical sciences, including application of psychological sciences to pathology
6. Social sciences, including anthropology, and sociology with special emphasis on the intrapsychic and interactional processes
7. Systems theories

In addition to obtaining academic competencies in these seven basic areas, the new Child Mental Health Specialist needs to have applied skills in:

1. Parenting
2. Clinical management, and
3. Education or special education

Above all, however, a child needs a generalist to provide for his total needs and not only a specialist to provide for his special needs.

The Child Mental Health Specialist does not concentrate on pathology and specific treatment techniques, as does the clinician oriented towards intervention. Instead, the Child Mental Health Specialist must be trained to deal with the whole child to help meet the disturbed child's total emotional needs. Unconditional positive regard towards the individual in dealing with the restructuring of a variety of behavioral manifestations or crisis situations needs to be emphasized. This requires the "family doctor" approach--a generalist for total needs. These abilities require an awareness of developmental dynamics and growth beyond the traditional categories of psychopathology (52). The initial development of such professionals began in 1970 at the Camarillo State Hospital, Children's Treatment Center, in Camarillo, California.

The Community in Which the Training Took Place

In addition to the Children's Treatment Center of the Camarillo State Hospital, three academic institutions and a number of child care facilities in Metropolitan Los Angeles have served as the training grounds for the Child Mental Health Specialists. The headquarters of the project, however, have remained at the Children's Treatment Center at Camarillo. The Camarillo State Hospital is located approximately sixty miles north of downtown Los Angeles and is easily accessible. The three academic institutions and the other applied training facilities all are located within easy commuting distance from Los Angeles.

The Facilities Participating in the Training

The major facilities participating in the training are:

1. California State University at Northridge
2. California Lutheran College at Thousand Oaks

3. Moorpark College at Moorpark
4. Children's Treatment Center of the Camarillo State Hospital
5. San Fernando Valley Child Guidance Center Day Treatment Center
6. Childrens Hospital of Los Angeles
7. Developmental Disability Clinic of the Pediatric Department at the Medical School at UCLA
8. Manhattan Project of The Salvation Army at Los Angeles
9. Ventura County Community Mental Health Center at Ventura
10. California Learning Center in Ventura
11. Dubnoff Center in Los Angeles
12. Ventura Head Start at Ventura
13. Satellite Treatment Homes in Camarillo and San Fernando Valley (used as an optional rotation)

The three academic institutions--The California State University at Northridge, California Lutheran College, and Moorpark College--serve primarily the local area (though, due to the parochial nature of California Lutheran College, a large portion of its population comes from outside the immediate area). The total enrollments are: 27,000 in Northridge, 9,400 in Moorpark, and 2,400 in California Lutheran. Although the hierarchy of the University of Northridge is more complex, the administrative structure of the three institutions is fairly similar.

All three institutions were quite receptive to the idea of developing a new Child Mental Health Specialist Training Program. Official approval was obtained by initiating discussions with interested persons within each institution in charge of

courses similar to those proposed for the Child Mental Health Specialist program. After thoroughly acquainting these people with the nature of the program and obtaining their support, other key people in the academic hierarchy were approached. These included Departmental Chairman, Dean of the Faculty, Chairmen of related departments who would have to cooperate in providing courses, etc. Generally, experience indicated that a new program was best developed if the courses in the proposed program were already listed under similar topic headings in various departments; i.e., it is easier to set up a program within an existing academic structure than trying to develop something new. It was also shown that if a new program (using existing courses) becomes successful and popular, it is much easier to institute variations on existing courses and to develop new ones.

Cooperation from the smaller agencies or institutions were the easiest to obtain, requiring only a brief period of negotiation. On the other hand, obtaining the cooperation of a larger institution such as California Lutheran College took more time. An even larger institution, California State University at Northridge, took considerably more time. Informal negotiations at various faculty and administration levels took several months. Then an additional number of months were required of formal negotiations by the university administration to obtain a consensus of the various university committees. Several dozen different approvals of individuals and committees were needed before the Child Mental Health Specialist Training Program had received its final go ahead.

The San Fernando Valley Child Guidance Clinic provides a day treatment service which was established to approximate a school setting while providing a

therapeutic milieu, educational therapy, and individual therapy and family counseling. There are six classrooms for forty children ranging in ages from five to fifteen. Each classroom has a credentialed special education teacher and a teacher aide. A psychologist and a social worker work closely with a given classroom. Together with the teacher and teacher aide, they comprise the classroom team. In addition to the teachers, aides, psychologists, and social workers, there are the director (psychologist), nurse, speech therapist, two recreational therapists, and psychiatrists.

The Child Mental Health Specialist trainees in this clinic are included as an integral part of the clinical team. They function in these classrooms as assistants to the teacher as well as assuming responsibilities for leading various classroom activities such as special academic projects, music, art, recreational activities, and field trips.

In conjunction with their classroom involvement, trainees receive additional educational experiences by:

- attending classroom consultation and weekly team conferences;
- attending weekly in-service conferences held by the Day Treatment staff;
- attending monthly in-service training provided to the entire staff at the San Fernando Valley Child Guidance Clinic at the Out-patient and Day Treatment Service;
- viewing videotaped lectures and demonstrations geared specifically to the training of social workers, Child Mental Health Specialist trainees, and psychology students;
- meeting with their own California State University, Northridge clinical supervisor and Day Treatment Service social worker to discuss topics relevant to their experiences at the clinic;
- attending weekly seminars conducted by the clinical supervisor to relate clinical experiences to didactic material, to express and gain

understanding of personal responses to their clinical experiences, and to hear guest speakers.

The Children's Center at the Camarillo State Hospital has a bed capacity for one hundred thirty to one hundred sixty children. There are five cottages where the children are located, a school building with playgrounds, a gymnasium, a large swimming pool, other recreational facilities, and an administration building. Four cottages are subdivided, each into two units with a bed capacity for twenty children each. The fifth cottage has a bed capacity for ten and is used for young children between ages three and six. The child population consists of a broad spectrum of diagnostic categories including severely psychotic, autistic, schizophrenic, severely neurotic, borderline psychotic, and delinquent youngsters. A typical unit of twenty beds has an interdisciplinary team consisting of a psychiatrist, psychologist, psychiatric social worker, two speech and language clinicians, two teachers, and about ten members of line personnel. The treatment programs are varied depending on the skills of the therapists and are geared to each child individually, taking problems, age, and sex into account.

The major clinical activities of the Child Mental Health Specialist trainee in the Childrens Hospital of Los Angeles are associated with the activity program for the patients. This program was established to help children cope psychologically with their medical experiences. The primary objective of the program is to provide for the psychological, social, and intellectual needs of patients. Recognizing and planning for these needs are emphasized in order to avoid or interrupt destructive emotional reactions to hospitalization. Currently, the program functions in five areas of the hospital. Each

program is unique, being determined by the ages of the children, their diagnosis, and their length of stay in the hospital. A therapeutic milieu has been created in each area with a range of activities that are appropriate to the age, developmental, and emotional needs of the children. The activities are multipurpose and selected with the explicit intention of offering children pleasurable experiences, encouraging peer interaction, and establishing trusting adult-child relationships. The structured, open-ended activities are appropriate at their bedside for individual as well as for small groups of children. Providing entertainment, recreation, or diversionary activities is not among the primary objectives of the program. The emphasis throughout the program is to offer a milieu that facilitates communication and encourages mastery of medical experiences.

The Developmental Disability Clinic at the UCLA Medical School has as its primary goal to provide an opportunity for each handicapped child to develop to the best of his potential and for each parent to understand his handicapped child's abilities and disabilities. The staff consists of a pediatrician trained in Child Development, teachers with Masters Degrees in Early Childhood Education and Special Education, physical therapist, occupational therapist, speech therapist, social worker, and parents. The major focus of intervention is the parent-child dyad in which the parent is seen as the most important agent of change. The program aims to help the parents gain confidence in their handling and knowledge of their child.

There are three separate programs within the total program. These are:

1. Home Intervention Program: Infants whose developmental age is under nine months are seen at home with occasional center-based visits by a team consisting of a teacher-therapist combination.

2. Infant Program: This program is for infants whose developmental age is about nine to eighteen months. There are eight infants in this group, and they attend two afternoons per week for one-and-one-half-hour sessions.

3. Toddler Program: This group consists of ten children whose developmental ages are between eighteen and thirty-six months. It meets five mornings per week for three-hour sessions. There is a great deal of flexibility in how often a child attends the program depending on his or her needs and the parents' desire.

The present population in the Developmental Disability Clinic includes children with cerebral palsy, developmental delays, emotional disturbances, chromosomal disorders, other neurological handicaps, and at least one normal child in each of the center-based programs. The children are grouped according to their developmental level, mobility, and readiness for social interaction. Homogeneity of the group is avoided. The nonhandicapped "volunteer" child serves as a model in play and language and as an initiator of social interaction. This also helps the staff and the parents observe the handicapped child in a more realistic perspective. Many of the mothers of the handicapped children have commented to the staff on the value of watching the nonhandicapped child interact with their children.

The Pediatric Department at the UCLA Medical School is a large pediatric hospital department dealing with children with a wide variety of problems.

The Salvation Army Manhattan Project works with young men and women from sixteen to twenty-five years. They include social misfits, addicts, probationers, and runaways. Many are students, others work part time or full time. Some have police records. Most come from unstable homes. Regardless of their backgrounds, all have problems. The program is mostly a self-help program with professional consultants

available if needed. The members of the project operate the program themselves under the guidance of the project director; they make the decisions and control the success or failure rate of the program.

The Ventura County Community Mental Health Center provides mental health services to both adults and juveniles in Ventura County, which has a catchment area of approximately 500,000 people.

The California Learning Center at Ventura deals with learning problems of children aged five to seventeen years who are slow learners, have learning disabilities, perceptual and motor problems, and are developmentally delayed.

The Dubnoff Center deals specifically with high-risk children aged eighteen months to five years who display varied emotional and physical handicaps.

Ventura County Head Start is a program of community aid to disadvantaged children aged three to six years.

Satellite Treatment Homes are Community Mental Health supported homes run by trained personnel (such as a man and wife parent surrogate team) who receive professional support from Community Mental Health and from the private practitioners.

Resources Available but Only Peripherally Involved in the Project

A number of community resources were used for shorter periods of time. These included such facilities as:

1. Detention homes
2. Nursery schools in the surrounding communities
3. Day care centers in the surrounding communities

Community Support and Resistance Initially Encountered

It was most encouraging and gratifying to encounter the interest and active support of people in the various community service agencies and academic institutions when they were approached regarding the training program. Service agencies were especially interested in being able to draw upon a source of professionally trained child care personnel. Cooperation in the training of students was readily obtained together with appropriate staff and time to provide the necessary supervision and training.

RATIONALE AND OBJECTIVES

The rationale for the training program is based largely on the result of experiences and developments in the field of mental health. In review, it has always been the practice to admit people who were thought to be mentally disturbed into a mental hospital. This not only protected society but also allowed the hospital personnel to deal with large numbers of patients. Initially it was thought that little or nothing could be done for the mentally disturbed. As a result, hospitalization consisted mostly of custodial care; and, usually, such care was of such quality that mental hospitals built up a reputation of being "snake pits." It was only during the last century that such pioneers as Pinel in France, Chiraugi of Italy, Benjamin Rush, Dorothea Dix, Clifford Beers and others in this country at the beginning of this century have fought for more humane treatment of the mentally ill (53). Now, of course, a treatment rather than custodial approach has become general practice; and mental hospitals are providing for increasingly effective treatment of their patients.

Yet, notwithstanding the great strides that have been made in the ability to treat mental illness in mental hospitals, new pioneers with vision and courage tell us that mental hospitals have become bankrupt and are beyond remedy. These pioneers tell us that new approaches must be adopted if we want to deal with the constantly increasing rate of mental illness in our population (54).

In general, these admonishments seem to have been accepted for adult patients as can be seen in the emphasis on developing community mental health centers rather than mental hospitals. Unfortunately, this practice does not seem to apply to dealing

with emotionally disturbed children. We still develop new mental hospital facilities for the treatment of the emotionally disturbed child. It appears that it has become a historical necessity to repeat the outmoded practices to which adult patients were exposed for children for whom no previous facilities were available.

This recapitulation of adult practices also can be seen when the development of child-care practices is traced. Some twenty years ago, for instance, it was quite customary to admit an emotionally disturbed child on adult wards. At that time, no special provisions were made to treat children in separate facilities. It only has been in the last two decades or so that people have started to recognize that emotionally disturbed children are not small emotionally disturbed adults and that such children need a different type of treatment than that which is provided for the adult emotionally disturbed patients. In those progressive hospitals where this principle was recognized, special provisions were beginning to be made for the separation of adult and child facilities. Such provisions, however, often consisted of only creating a separate ward to which all children were admitted regardless of the immense chronological age and physical age as well as mental maturity differential among them. For instance, a four year old has needs which are quite different from those of a six year old, or a nine year old, or a fourteen year old. When these children with these disparate ages are put together on the usual forty-bed ward, one can imagine what sort of problems existed. Moreover, if one considers that, in general, children are so much more active than adults and that emotionally ill children often exhibit severe destructive behavior, one can imagine the confusion and bedlam which usually existed on such large wards. This condition is exacerbated since, regardless of the separation of children and adults,

treatment on the children's ward often consisted mostly of custodial care necessitated by staffing patterns. In addition, such conditions made it impossible to pay attention to each individual child. The usual staffing pattern was, and often still is, such that the staff had their hands full in dealing with emergency after emergency which usually occurs in settings of this type. As a result, the staff were incapable of really treating these children regardless of whether they were prepared to do so or not.

Over the years, staffing ratios on children's wards have become somewhat better. Simultaneously, the size of the ward has decreased, thus making it possible to focus on dealing with the problems of the children and not mainly on custodial care. Notwithstanding these improvements, the treatment of mentally disturbed children remains a problem of monumental proportions, especially since the rate of emotional disorders among children in the population has continued to rise. For instance, the National Institute of Mental Health (55) estimated that in 1962 there were approximately 60 million children in this country under the age of fourteen, representing approximately 30 percent of the total population. Surveys of school populations in several cities, such as the Los Angeles Survey by the MacMillan group (56), showed that between 7 and 12 percent of the school population had emotional problems and required help. Based on these figures, it was estimated that between 2.5 and 4.5 million children under the age of fourteen were in need of some help for their emotional problems. Figures for 1963 showed that a total of 295,000 children under the age of eighteen were seen in outpatient psychiatric clinics and that only approximately 30 percent of these children received diagnostic and treatment services. Another 265,000 children under the age of seventeen appeared in juvenile courts on petitions of neglect and delinquencies. Estimates of current

child population and young people under twenty are closer to the 80 million mark. The Mental Health Association estimates that "5 million children have some form of mental disturbance and probably twice that many." Approximately 60,000 children and young people are in state and county mental hospitals requiring extensive long-term treatment (57). These figures show the enormity of the problem with which one is faced.

It is impossible to provide proficient treatment for young children, especially those in the age group between four and twelve years, without becoming intimately involved in their lives. The care of children often provokes in the staff who treat them the entire gamut of personal feelings, ranging from disgust on the one end of the spectrum when one is constantly confronted with young children who habitually smear feces, to compassion and high motivation in helping these young children at the other end of the spectrum. In the older children, one goes through the spectrum of rage and anger on the one hand, to feelings of empathy and understanding for their problems and a sense of commitment of helping them on the other hand. At which end of the spectrum of feelings the staff member will react to the child's provocative behavior, and how he will translate these feelings into actions will largely determine the outcome of the treatment. It may decide the child's future, for better or for worse.

The treatment of emotionally disabled children requires warmth and understanding in the adult staff. In addition, the staff must be aware of the fact that they will have either these negative or positive feelings towards a child and that they must learn to discipline and control these feelings and use them effectively in the handling of such children. Because emotionally disturbed children generally cannot articulate their feelings and can be overwhelmed and pushed into further withdrawal by, for instance,

a punitive attitude on the part of the staff, a great deal of damage to a child can occur if the staff do not learn to control their attitudes. It is, therefore, of the utmost importance that competent and dependable personnel can be placed in key positions in various treatment programs.

The behavior of a mentally ill child must be understood as a kind of symbolic language. They are not crazy, if you know them. It is their way of saying that they are unhappy and distressed. It requires an ability to interpret the symbolic language of the emotionally disabled child to know how to treat these children most effectively. To really deal with the emotionally disabled child in a meaningful manner, it is necessary to provide a proper emotional environment where specially trained people have the opportunity to interact with the child in a manner which meets his emotional needs. In order to discontinue mistakes which are inherent in our present treatment approach for emotionally disabled children, we must be visionary enough to initiate new concept and practices of child care. The aim must be to provide for these ill children the kind of treatment which will maximize their mental growth and adjustment; the kind of help they unfortunately are unable to receive either in their own home or in a hospital setting. This means that the total child and his many-faceted needs must be treated. It means that the child must have a responder to relate to who has the empathy and sensitivity of an ideal parent, some of the information and knowledge of a special teacher, and the basic tools and skills of a child therapist. The treatment of the child must be handled by someone who has the sophistication to understand the symbolic meaning of the children's behavior as expressed in their daily interaction with grown-ups. Thus, this person knows how to respond to these symbolic communications in a manner which would lead

to a successful restructuring of the child's emotional life. Such a person must also have the ability to work through the tremendous frustrations which result from spending many hours daily with mentally ill children in close conditions.

The training of such people must be flexible. This is required because such people must be able to operate in different situations. They must be able to staff such places as day care centers or special education classes in preschool, elementary, or high schools. This means that different levels of training are needed because different intensities of child care are desired in different situations. These situations range from dealing with normal children in possibly summer camps or day camps, to dealing with slightly neurotic children, the more neurotic or disturbed delinquent children, to psychotic and severely disturbed children. A training program also needs to be flexible because the trainee needs options for future development. In our fast-changing society, contemporary trainees should be able to meet changing needs. In the past, the training of people has been somewhat parochial. For instance, psychiatric technicians are basically trained to provide only custodial care primarily in hospital-type settings. Now that the trend is towards community care, this change in treatment focus is jeopardizing their continuing employment. Contemporary training, therefore, should ensure that trainees have future employment security by providing them with the option to assume a variety of roles. It is visualized that persons trained in providing care and treatment of emotionally disturbed children will be able to apply their talents in community mental health centers, in hospitals, in day care centers, in special education classes, in school situations, in foster homes, in boarding homes, or in homes for surrogate parents. A generalist type of training, therefore, will make it possible to provide

a fully integrated treatment and prevention service rather than the customary fragmented--and often disjointed--approach in dealing with emotionally disturbed children.

Such generalists are the new Child Mental Health Specialists.

The initial program for the training of this type of professional consisted of a two-year training program of fifty weeks each year at the Children's Treatment Center of the Camarillo State Hospital. Initially, the program was geared for college graduates only since it was felt that they would be more mature and capable of grasping all that was involved and were far enough removed in age from adolescence to provide a parent-like image. Students received an interdisciplinary academic background. They were taught by clinicians from the fields of medicine, psychology, social service, nursing, speech pathology, and education. The emphasis of the training was on working with the child as a whole rather than as a product of many separate and distinct problems. From the very outset of the program, the student was involved in at least twenty hours per week of clinical experience. These experiences were always immediately related to and integrated with academic training taught by experienced clinicians. The key concept in the training of the Child Mental Health Specialist is that the training program must provide clinical experiences from the first day on and that the academic or theoretical correlates are applied after the situation has been experienced. Child Mental Health Specialists should be trained primarily in a practical setting in which they receive firsthand experiences with the behavior of emotionally disturbed children. The trainee must receive firsthand "gut" learning and experience the different pathologies which are exhibited by the emotionally disturbed children before they receive the academics which

are related with the experiences. This approach is a variation of the traditional approach where usually the academic learning precedes the clinical learning. Unfortunately, as most of us know all too well, the academic theory which most of us have experienced first had little or no meaning since we were unaware of the actual behaviors which were associated with them. In the present approach, there is first clinical learning; and this is immediately backed up with academic learning. Thus, there is no fragmentation of approach in contrast to the usually considerable time lapse between what is learned in the classroom and what one can experience firsthand in a clinical setting. As a result, the Child Mental Health Specialist is intimately able to understand and interpret the symbolic meaning of the behavior of the emotionally disturbed child.

Levels of Training

It soon became evident that one training program was not sufficient. A variety of levels of academic background was required to satisfy all the needed roles a Child Mental Health Specialist would be able to perform and for which he could be responsible. A hierarchy of different competencies and varying levels of sophistication were needed to meet the different treatment needs of a wide variety of disturbed children. As a result, the original Camarillo program was expanded in conjunction with the various academic institutions and local community facilities to encompass three different levels of training. These are:

1. An Associate of Arts Degree--which consists of a two-year training program and trains its graduates to function competently in residential

treatment facilities, as teaching assistants in special as well as traditional classrooms, to help Head Start staff, community mental health center staff, and nursery schools staff;

2. A Bachelor of Science Degree--which requires an Associate of Arts Degree plus an additional two years of training. Graduates with this degree work with programs directed towards delinquent children and adolescents, they function as program directors of nursery school and Head Start programs, as research assistants, and Satellite Home parents;

3. A Master of Science Degree--which requires a Bachelor of Science Degree plus an additional two years of training. This program provides the graduate with teaching credentials in special education. Master of Science graduates, besides being able to function in more senior levels in the situations in 1. and 2. above, may also function in a supervisory and managerial capacity.

The aim of the training program is to train a professional who will be skilled in effectively managing children in age ranges from birth through adolescence, a professional who can deal sensitively with the needs of the total child. To accomplish these ends, the program is designed to provide this new professional with knowledge and skills from a variety of professions such as psychiatry, psychology, counseling, speech therapy, teaching, and nursing. The training program also provides opportunities to participate actively in interdisciplinary teamwork.

Throughout the training the whole child, rather than a particular pathology, is emphasized. In order to accomplish these aims, the trainees are exposed to multiple aspects of the child, his environment, related family problems, as well as to a variety of clinical techniques for dealing with them. At the end of the training, the trainees are prepared in nine major areas:

1. family therapy
2. group therapy

3. parent education
4. play therapy
5. early intervention
6. communication disorders
7. crisis intervention
8. administrative skills for child facilities
9. child advocacy

Preparation in these areas is achieved by providing the trainees with a balance of both academic and clinical training. The articulated purpose of the program is to prepare professionals who are fully capable of integrating theory with practice in the treatment of children. Each trainee is required to spend at least twenty hours a week actively engaged in a clinical rotation during the length of the training program, whether the Associate of Arts, Bachelor of Science, or Masters Degree programs. Thus, each trainee goes through six such rotations, each lasting approximately four months. Clinical rotations are conducted under the direct supervision of a Children's Unit staff member throughout the course of the program. The trainees are provided with a wide variety of clinical experiences. The rotations are designed to ensure experiences which encompass different types of children, children of different age and sex, nature and severity of illness.

Specific Needs Being Met

Specific needs being met include:

1. Filling the gap which exists between the body of professionals such as child psychiatrists, child psychologists, speech therapists, play therapists, and special education teachers, and the nonprofessional line personnel who have the major responsibility for the day-to-day, continual care of severely disturbed children.

2. Training a professional who will be skilled in effectively managing children in ages ranging from birth to adolescence and who can deal sensibly with the needs of the total child.

3. Training a professional who will, after some years of experience, provide leadership in the field of child care and treatment in the years and decades to come.

4. Providing contemporary training which would ensure that trainees would have future employment security by providing them with the option to assume a variety of roles.

5. Providing a training which would provide a fully integrated treatment and prevention service rather than the customary fragmented and often disjointed approach in dealing with emotionally disturbed children.

TRAINING ACTIVITIES - CURRICULA

The general aim of the curriculum was to cover, as much as possible, those aspects of child care which other training programs and experts in the field stressed as being of primary importance (see Tables 1, 2, and 3).

Since nearly all courses, especially at the initiation of the training program, had to fit into the existing academic course pattern, not all aspects could be included. This was more the case, of course, for the Associate of Arts program than for the Bachelor and Masters Degree programs. In addition, there were limitations in the number of course units which could be included into the respective training programs. Another important aim of the curriculum was to prepare the trainees, as much as possible, for the proposed responsibilities they were expected to assume upon graduation. These responsibilities are discussed in "Levels of Training" immediately above.

Specifically, the courses in the initial training program for the various degrees are as follows (see Tables 4, 5, and 6):

TABLE 4

Courses in the Experimental Associate of Arts Degree Program
for Child Mental Health Specialists
(for final list, see Table 13)

1. Child Growth and Development
2. Observation in the Nursery School
3. Child, Family, and Community
4. Psychopathology of Childhood
5. Adolescent Psychology
6. The Exceptional Child Practicum
7. Behavioral Techniques
8. Supervised Participation in the Nursery School
9. General Psychology
10. Group and Individual Counseling Techniques
11. Directed Child Care Practitioner Training
12. Crisis Intervention
13. Family Counseling
14. Speech and Language--Assessment and Intervention

TABLE 5

Courses in the Experimental Bachelor of Arts/Science Degree Program for Child Mental Health Specialists
(for final list, see Table 14)

1. Growth and Development I and II
2. Communication Disorders I
3. Child Development Treatment and Services
4. Abnormal Psychology
5. Contemporary Systems
6. Behavior Modification
7. Clinical Aspects of the Minority Child's World
8. Physiological Psychology
9. Exceptional Child Practicum
10. Dependent Child--Social Work
11. Statistics
12. Family Counseling
13. Crisis Intervention
14. Advanced Child Development Treatment and Services
15. Juvenile Delinquency--Probation
16. Introduction to Counseling and Psychotherapy
17. Experimental Psychology

TABLE 6

Courses in the Experimental Master of Arts/Science Degree Program
for Child Mental Health Specialists
(for final list, see Table 15)

1. Child Growth and Development
2. Learning Disabilities I:
   Reading Procedures
   Assessment and Remediation
3. Learning Disabilities II:
   Math Procedures
   Assessment and Remediation
4. Selected Topics:
   Methods of Multicultural Education
5. Field Study: Special Education
6. Seminar: Child Development
   Treatment and Services
7. Diagnostic Testing
8. Language and Speech Development
   and Disorders
9. Multiple Handicapped, Emotionally
   Disturbed, and Autistic
   (Behavior Modification)
10. Organic and Cultural Basis for
    Severely Handicapped
11. Diagnostic and Prescriptive
    Teaching of Reading
12. Field Study
13. Management of Learning Laboratory
    (Social Studies, Math, and Science)
14. Learning Disabilities III:
    Motor-Perceptual Procedures
15. The Severely Disturbed Adolescent
16. Counseling Exceptional Children
17. Psychology of the Exceptional Child
    (Psychopathology of Childhood)
18. Statistics
19. Directed Teaching
    (or)
    Field Study: Special Education
20. Seminar: Child Development
    Treatment and Services
21. The Dependent Child--Social Work
    (or)
    Juvenile Delinquency--Probation
    (or)
    Public Administration
22. Philosophers on Education
    (or)
    History of Education
23. Psychology of Learning
24. Directed Teaching
    (or)
    Field Study
25. Crisis Intervention
26. Techniques of Teaching the
    Severely Handicapped and
    Working with Their Parents
    (Play Therapy)
27. Learning Characteristics of the
    Developmentally Disabled
28. Methods of Research (and)
    Thesis or Project
    (Both needed if not doing
    comprehensive exams)
29. Seminar: Learning Disabled,
    Behaviorally Disordered,
    Educationally Handicapped
    (Includes Adolescence)

Course Outline and Content

Each of the courses in the experimental Associate of Arts, Bachelors, and Masters Degree programs is described in terms of:

a. outline of course content

b. methods of evaluation

c. suggested texts and materials

d. movies--where applicable

A complete set of these descriptions is provided in Appendix II.

Methods of Instruction

A variety of methods of instructions were used including lectures, seminars, direct supervision of clinical work, T meetings, videotapes, films, slides, modeling, and role playing such as being a stutterer, blind, or aphasic. The aim of the instruction was not only to impart information but to make the trainee an active participant.

Unique Approaches to Teaching

Probably the most unique aspect of the training program is that the academic course work augments the clinical experiences under supervision which the students receive simultaneously with their academic training. This has been most effective and salubrious in making the program meaningful and relevant.

The interdisciplinary team to which the students were exposed in their clinical training also has been very beneficial. The team provided for different philosophies and emphases in the training and taught the trainees different competencies.

One of the most important aspects of the training program has been the recognition that specific attention must be paid to the "process" of training. Having "content" is not sufficient. It is through the process of training that a training program achieves success and that competent and understanding students are trained. In any training program, there are many interactions to which the trainees are exposed. They relate with each other, with their teachers, and with the children. In each of these relationships each side affects the other. There must be an opportunity to sort out the various feelings in a constructive manner. This was done in part by T meetings, psychodrama in which trainees were able to act out their feelings, workshops, role playing, and consultations with the individual student's supervisor.

Reading Lists

In all of the courses in the three experimental programs, reading lists were provided. These are included with the course content descriptions in Appendix II.

INTERNSHIP AND FIELD EXPERIENCES

Clinical rotation services are probably the most crucial part in making the entire training program a success or a failure.

It cannot be stressed too much that trainees need to have a wide variety of applied experiences. Thus, it is vitally important that a number of different child care facilities are available to trainees during their training program. The primary settings in which trainees need to work are:

1. various day care facilities
2. various residential settings
3. school settings including learning centers, nursery, kindergarten, elementary and high school
4. children's hospital facilities
5. pediatric clinics
6. probationary facilities for the Justice System for juveniles

It is not sufficient for the trainees to be only observers. They must have the opportunity to participate actively in the ongoing day-to-day activities. In addition, professional staff time must be available to these trainees to teach, guide, and discuss with them what they are involved in.

It was found that the success of the training program depends not only on the availability of a variety of applied settings but also on the opportunity to interact with the staff and learn from them.

It is mandatory that each student spend a minimum of at least twenty hours of direct work with individuals and groups of children under staff supervision. Each student goes through six rotations through the respective training periods. Each rotation is four months in duration. During the rotations the students deal with children of different ages and different behavior problems. Experiences in residential care were provided by the Children's Treatment Center at the Camarillo State Hospital. Other treatment experiences were provided by the San Fernando Valley Day Treatment Center which had several classrooms for a total of about seventy children with a wide variety of problems. Experiences with normal children were provided by the public schools and a Child Guidance Clinic.

During the last two years of the training program the rotation services included experiences at the Childrens Hospital of Los Angeles. The latter was added to give the students supervised experiences in providing psychological care for normal children who are hospitalized for medical and surgical reasons. In addition, the students will receive experiences in a milieu that facilitates communication and encourages these children to master their fantasies and fears of the impending medical and surgical experiences. Another rotation also was added which included the Developmental Disability Clinic at the University of California, Los Angeles Medical School in order to develop skills in dealing with developmentally disabled children during infancy and preschool age. A similar rotation was added at the Pediatric Department at the same medical school to develop the skills for helping mothers to deal with children at risk and with normal infants.

Other clinical experiences included the Dubnoff Center which offers an intensive cross-disciplinary program in working with high-risk children whose families

represent the entire socioeconomic and educational range, practical experiences in on-site teaching with toddlers and preschoolers, seminars on developmental evaluation of children, intervention techniques, case presentations, group supervisory sessions, and individual conferences.

In addition, educational and clinical experiences are provided at the California Learning Center in Ventura, at the Ventura Head Start program, and the Continuing Care Services Section of the California State Department of Health.

More specific details of the clinical rotations, including the populations with whom the students will be working and available learning experiences and responsibilities, are described in Appendix II.

Summary tables outlining the various rotation facilities and the respective activities in which the Associate of Arts, Bachelor, and Master Degree trainees should be involved are shown in Tables 7, 8, and 9.

TABLE 7

Clinical and Educational Rotation Services
in the Associate of Arts Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage Preschool age and school age children	-implementation of preschool treatment under supervision -one-to-one with autistic children -developing daily self-care skills: teeth brushing, hand washing, bathing, dressing, feeding, bed making -observations, keeping notes	Nursery School: College or Community	-supervised nursery activities -plays and games -affective interaction with children
		Therapeutic Nursery School	-one-to-one play therapy -small group affective interaction -behavior control
CTC: Cottage Youngest children, ages 3 to 8, both sexes, autistic children	-participation in preschool and kindergarten activities -motor-perceptual training -sign language -speech language -self-care skills training -learning to coordinate total program for one child, including parents and community -monthly report on child -participation in team meetings -behavior modification training	Head Start	-parenting -stimulating plays and games -teaching assistant -control of behavior
		Day Care Center	-parenting -recreational activities -nursery activities -group activities
		Kindergarten and Elementary School	-teaching assistant -affective interaction -discipline -recreational activities -arts and crafts activities

*CTC--Children's Treatment Center

continued

TABLE 7 continued

Clinical and Educational Rotation Services in the Associate of Arts Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage Chronic psychotic young adolescents; hospital duration: 6 to 18 months	-implementation of behavior modification oriented treatment -active, ongoing therapies -participation in group therapies, 4 times a week, with Gestalt orientation, also psychodrama -participation in recreational therapies, also cooking classes, arts and crafts, and physical exercises	Playgrounds, Community, Neighborhoods, Camps, Recreational Parks	-recreational activities -safety rules -group leadership -control of behavior -affective interaction in one-to-one
CTC: Cottage Young adolescent girls, aggressive, asocial, and dyssocial	-participation in group therapy -individual one-to-one -one-to-one tutoring -physical education activities in afternoon -off-grounds activities in the evenings		
CTC: Cottage Children, ages 7 to 14, mixed types, boys and girls, (continued)	-normalizing activities of small groups: table games, creative courtyard play, bike safety, body-movement (continued)		

continued

TABLE 7 continued

Clinical and Educational Rotation Services in the Associate of Arts Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage (continued) severe personality disorders, severe brain damaged, and autistic children	training, swimming, day camp, community trips, one-to-one activities for small groups		
CTC: Gymnasium, Playgrounds	-physical education -dealing with behavior problems -discipline -supervised recreational activities		
CTC: Classroom Boys and girls, very low academic skills, poor speech and language, function around first-grade level	-group activities in circle, singing, letter recognition, table activities, puzzles, crafts, audiovisual films, filmstrips, individualized work, art, snacks, playground, physical education activities		

TABLE 8

Clinical and Educational Rotation Services
in the Bachelor of Arts/Science Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
Adolescent Treatment Center: Cottage Short term, acute psychotic adolescents, ages 16 to 18, male and female	-participation in group sessions -Recovery, Inc. -group realization -one-to-one relationship with patients -planning appropriate treatment schedule under staff supervision -participation in milieu therapy -team meetings -charting, reporting	Head Start	-plan, design, and direct Head Start activities -family counseling
		Day Care Center	-plan, design, and direct day care center
		Satellite Home Parents	-to function in the role of psychological parents and to provide emotional support for a period of several weeks or months to children who need to be separated temporarily from a traumatic home environment
Adolescent Treatment Center Autistic adolescents	-participation in behavior development -closely supervised one-to-one work with autistic adolescents		
CTC: Learning Laboratory Severely psychotic children	-research assistant in behavior research laboratory -control hyperactive, nonverbal, psychotic children -relate well to staff -carry out experimental operations exactly -make intelligent observations and report	Children and Adolescents in Difficult Home Situation with Both or One Parent Only	-after-school and weekend activities setting up recreational activities for small groups in neighborhoods, for children and adolescents -provide emotional support to one-parent

(continued)

*CTC--Children's Treatment Center

continued

TABLE 8 continued

Clinical and Educational Rotation Services in the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage Mixed types of children, ages 7 to 14	-clinical assistant role -assist in play and small-group therapy sessions, ongoing basis, includes program-wide group treatment -observe and assist with testing -assist in activity planning and implementation level -conduct activities independently -report results to supervisor and treatment team	Children and Adolescents in Difficult Home . . . (continued)	home -family counseling -arts and crafts activities -sports, etc.
Adolescent Treatment Center Long-term psychotic adolescents	-work with verbally responsive adolescents -structured level system -group and individual therapy -trainees receive psychodrama and assertion training in work with individuals and groups -individual resources or talents such as music, drawing, and painting are used	Services to Violent Families	-application of social/psychological principles to increase the policeman's effectiveness in handling such problems -help parents deal with underlying fear, hurt, and frustration -educate parents to the psychodynamics of child development -identify high-risk families and deal with family dynamics
		Police Station Truants from home or school, for boys and girls	-improve police/community relations, especially in minority group problems -sensitize police to social/emotional problems -involvement of boys (continued)

continued

TABLE 8 continued

Clinical and Educational Rotation Services in the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Classroom Adolescent girls with various behavior disorders and acting-out problems	-trainee assists the teacher in both the implementation and planning of school activities -student takes the responsibility for the classroom for a pre-arranged period of time under teacher supervision -trainee assists the teacher with controlling children on the behavioral level and with performance on the academic level	Police Station (continued)	and girls in YMCA recreational and sports activities -provide emotional support to families
CTC: Classroom Highest functioning group of adolescent girls, but small and immature, poor social skills, poor self-control, poor frustration tolerance, close to normal academic level	-classroom activities offer three overlapping behavior rewards systems which are continually revised to meet the needs of the children -trainees participate in the operation of the daily school program including team meetings and field trips -trainees may try their own ideas		

continued

TABLE 8 continued

Clinical and Educational Rotation Services in the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Classroom All boys, ages 9 to 14, acting-out, aggressive, destructive, academically mixed, slow learners, some up to grade level	-limit setting, fine motor program and gross motor program -physical education -group activities in academic and physical education		
CTC: Speech and Language Laboratory Boys and girls, ages 7 to 15, psychotic, autistic children	-evaluation -testing -behavior modification -group and individual sessions -social skills training -possibly deaf education -working with small groups in individual speech therapy -dealing with receptive language skills and expressive skills		
CTC: Adolescent Cottage High- and low-functioning autistic children and adolescents	-ongoing supervision in sensorimotor integration, treatment techniques, and evaluations (continued)		

continued

TABLE 8 continued

Clinical and Educational Rotation Services in the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Adolescent Cottage (continued)	-practice in writing up treatment plans and carrying out treatment under supervision		
Probation Department; Youth Authority	-individual and group counseling -educational tutoring -mechanical and industrial skills development -vocational guidance -camp activities -backpacking		

TABLE 9

Clinical and Educational Rotation Services
in the Master of Arts/Science Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage Adolescent boys, ages 12 to 16 behavioral aggression, inability to get along, school failure, run away, family conflicts	-limit setting -crisis management -counseling -confrontation -emotional first aid -life-space interview -supportive therapy -diagnostic evaluation -interpretation of behavioral acting out -learning about family dynamics -interacting with families during admission and family conferences -individual and small-group therapy assignments	UCLA Medical School, Pediatric Department Child Development Vulnerable or difficult infants, toddlers, young preschoolers Three different programs Home intervention for infants zero to 9 months Toddler program, developmental ages 18 to 36 months Infant program, 9 to 18 months	-admissions -social intervention -analysis of developmental areas -motor -adaptive -language -preschool -social -community work -research -help mothers develop children's full potential -member of interdisciplinary team: pediatrics, psychiatry, surgical, orthopedics, education, special education -parent-teacher training to become agent of change in child's development
CTC: Cottage Preadolescent and adolescent children, mixed group, nonverbal, verbal schizophrenic; high-functioning, aggressive adolescent boys	-collaborate with psychologist, social service worker, sensorimotor integration therapist, speech pathologist, as co-therapist with increasing autonomy	Childrens Hospital of Los Angeles -infants, toddlers, preschool, adolescents (continued)	-multipurpose -provide psychological, social, intellectual needs of patients (continued)

*CTC--Children's Treatment Center

continued

TABLE 9 continued

Clinical and Educational Rotation Services in the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage Adolescent boys, ages 12 to 15, chronic schizophrenic, acting out, and borderline psychotic	-speech and language therapy -receptive language skills, some expressive skills using specific speech and language techniques and rationale for their use	Childrens Hospital of Los Angeles (continued) Acute medical/surgical illness, or long-term chronic disability Four different programs for acutely and chronically ill children and adolescents	-facilitate communication between children and staff -encourage mastery of medical experiences -promote activities of children rather than passively receiving treatment -encourage expression of fears, fantasies connected with imminent medical and surgical treatment -affective interaction -group activities -individual play therapy -parents' education and parent effectiveness training program, mostly workshops
CTC: Cottage Adolescent girls, acting out, asocial and antisocial	-group leader -cotherapist of large psychotherapy groups -design and implement individualized treatment program -one-to-one work with girls -participate in admission and preadmission screening -placement planning -visit placements -active participation in family therapy -participation in all unit and staff meetings	Well-Baby Clinic	-provide guidance to mothers in Well-Baby Clinic for normal and vulnerable infants
CTC: Cottage Broad range of children, (continued)	-introduction into sensorimotor integration therapy (continued)	Dubnoff School 18 months to 5 years (continued)	-intensive, cross-disciplinary program -high-risk children of (continued)

continued

TABLE 9 continued

Clinical and Educational Rotation Services in the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Cottage (continued) mostly autistic, brain damaged	-testing -evaluation -writing treatment program and implementation	Dubnoff School (continued) -varied physical and emotional handicaps	broad spectrum of socioeconomic and educational family background -on-site experience of managing and teaching toddlers and pre-schoolers -participation in seminars on developmental education of children -intervention techniques -case presentation -group sessions -individual conferences
CTC: Classroom Adolescent boys and girls, up to age 16	Special Education: -laboratory methods of teaching -daily lessons and theory and practice skills -management of discipline problems -limit setting -individual behavior modification treatment -level system -management of group interaction -class discussion of individual treatment plans -work with individuals and small groups -involvement in therapist-teacher discussion concerning individual children	Public Schools Normal children	-application of child mental health principles to education in the classroom with focus on process and mutuality of experience between teacher and students, students and students -teaching is not limited to imparting information, but to help children develop their (continued)

continued

TABLE 9 continued

Clinical and Educational Rotation Services in the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
Community Adolescent Treatment Center Innovative community program for adolescents, ages 16 to 18, coeducational Referred by probation department, public schools, and welfare agencies	-to meet social, educational, vocational, and psychological needs, whose problems require placement out of their homes -developing self-image, sense of self-worth through positive spiritual, psychological, social, and emotional experiences -staff and residents combine efforts to support each of the residents in decision-making and goal-setting experiences -create an atmosphere in which the individual can mature by decision making	Public Schools (continued)	psychological potential for appropriate age levels through decision-making process to prepare students to be active participants in a democratic society -planning special projects with intergenerational participants in which mental health principles can be applied and participated in by the students -teaching students functional parenting and training for future parenting -using day care centers, Head Start, nursery schools, baby-sitting, where they can apply their knowledge
Continuing Care Services Section: in the community Children of all ages	-administration, office organization, management of records and files -casework -participation in placement (continued)	Community Mental Health Centers; Public Health; Obstetric Departments of Medical Schools; Pregnant Women	-anticipatory prenatal guidance -providing emotional support for pregnant mothers to be (continued)

continued

TABLE 9 continued

Clinical and Educational Rotation Services in the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
Continuing Care Services Section: in the community (continued)	-involvement in community program -participation in meetings of Citzens' Advisory Board -Child Advocacy	Community Mental Health Centers; Public Health; Obstetric Departments of Medical Schools; Pregnant Women (continued)	-member of team -teaching mothers the psychodynamics of child development and the importance of awareness of affective interchange between mother and infant, particularly during the first few days and weeks of the infant's development
Community Learning Center Children and adolescents, ages 5 to 17, learning disabilities, slow learners, perception problems, motor problems, developmentally delayed	-testing -evaluation -designing individualized program for students to remediate reading, math, perception and motor problems		
CTC: Classroom Adolescent boys and girls, ages 12 to 15	Special Education: -planning daily school program on different grade levels, mostly individual but some group work -special projects for outdoors -diagnostic tests (continued)		

continued

TABLE 9 continued

Clinical and Educational Rotation Services in the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Clinical/Educational Rotations/Situations	Activities	Clinical/Educational Rotations/Situations	Activities
CTC: Classroom (continued)	-setting up academic curriculum -group teaching, various subjects -science, social studies -develop various techniques for teaching children		
CTC: Classroom High-functioning academic students, elementary classes	Special Education: -teaching techniques -reading, spelling, phonics, handwriting -cognitive skills -perceptual fine motor skills -group and individual -operant techniques -assessment and prescription		

The Role of the Cooperating Facilities

The cooperating clinical facilities had agreed to integrate the trainees with their clinical staff so that they were able to participate in the various clinical activities of the facility. In addition, specific staff members were assigned to supervise the trainees and provide the necessary guidance.

Supervisory Activities

The clinical supervisors were responsible for guiding and directing the trainees during their training. They were part of the support system for the students and assisted them in coping with their feelings and frustrations in working with problem children. In addition, the supervisors were available to assist the students with problems involving interpersonal relations and the training program in general.

STRENGTHS, WEAKNESSES, AND UTILITY OF CURRICULUM

Strengths

An evaluation of the Child Mental Health Specialist Training Project was done by the Center for the Study of Evaluation of the UCLA Graduate School of Education (58). The results of this evaluation are discussed in more detail in a following section. Findings relevant to the strengths of the training program curriculum include:

1. The provision of a logical progression of courses and course content.
2. A broad academic base at all three levels allowing the trainee to branch to other professional training programs.
3. The integration of academic training with employment careers at each of the three levels.
4. A curriculum designed to dovetail with clinical experiences.
5. The ability of the program to integrate clinical and academic components.
6. The multidisciplinary experience of the training staff.
7. Program implementation largely as originally planned.
8. Deviations in the training program only in response to student suggestions and needs, or the necessity to be flexible to unanticipated constraints.
9. The development of a clear sense of competence in areas of child mental health care by graduates and trainees.
10. The development of attitudes that will assist graduates and trainees in the completion of their duties in a child mental health care framework.
11. Clear distinctions in self-assessed competencies among degree levels of the program, with clearest differences between the Associate of Arts and Masters Degree levels.

Weaknesses

The UCLA evaluation study identified a number of weaknesses of the present training program. They can be described as follows:

1. Lack of definition of desired program outcomes. Operationalized domains of competencies are not sufficiently identified and clear performance indicators applied to assessing program effectiveness.

2. The relationship between degree-granting institutions and the training program should be strengthened. More active interest in the training program by the colleges would be desirable.

3. Limitations on student stipends, which constrains trainee population to those who can afford to devote full time to the program.

4. Lack of consensus about program goals and means of achieving them.

5. Inadequate orientation to the program for staff, academic personnel, and trainees.

The lack of consensus about program goals and means of achieving them is reflected in the lack of definition of desired program outcomes in terms of specified domains of competencies. The lack of consensus was mainly due to the fact that staff from a variety of places were involved in the training program without having had the opportunity to have sufficient orientation of training themselves. As a result, these staff maintained many of their own biases, emphases, etc.

The lack of established operationalized domains of competencies is mainly due to the lack of personnel who could devote sufficient time to integrate individual rotation goals and course objectives into one overall set.

It is suggested that this aspect should take place as part of the program dissemination phase.

It is clear from the above findings that more communication among the various parties--clinical and academic staff, relevant academic individuals and committees, and students--should take place. Specific orientation programs for all staff and students should take place. Such orientation programs for all staff and students must precede the beginning of each training program.

An additional evaluation was done one year later in order to ascertain whether instituted modifications had improved the program. It was found that, where possible, the original program deficiencies had been improved or eliminated; and goal definitions had been clarified.

Utility of Teaching Materials

A number of teaching materials were developed. These included: course outlines, reading lists, lists of movies, modeling, role playing, psychodrama, and "life" demonstrations.

TRAINEES

Selection Criteria

The selection criteria included both an academic and clinical screening procedure. An application form was devised to elicit information about the applicant's basic work experience and other needed personal and administrative information. Transcripts had to be submitted to allow the assessment of the applicant's general academic level and to provide an expectation of the academic performance in the Child Mental Health Specialist Training Program. Along with the transcript, the applicant needed three references from people who knew him or her. These reference letters were used to provide information on the applicant's character, dependability, sense of responsibility as experienced by others, and an opinion on the applicant's suitability for work with children and the applicant's promise for potential personal and professional growth.

The second phase of the selection procedure consisted of a personal interview of the applicant by an admission committee. This committee tried to evaluate each applicant in terms of integrity, openness, amount of defensiveness, activity rather than passivity, creativity rather than conformity, dependability, sense of curiousity, sense of commitment towards children, emotional stability, ability to work under stress and capability to turn adversity into positive gains, motivation, ability to relate to authority figures, interest, and personality functioning.

In the third phase of the selection procedure the applicant was asked to spend two separate four-hour clinical periods in two different clinical rotations in which they

had to interact with several children under direct supervision. Generally an applicant is exposed to experiences with both the autistic and schizophrenic child as well as the behavioral acting out. The aim of this third selection phase is to provide some means of assessing the ability of the applicants to relate to children, especially how they react to a crisis or impending crisis situation. The conclusions of the interview and the clinical observations are recorded and tabulated by each of the observers according to a rating scale of one to five in the following ten areas:

1. Self-starter
2. Insight: self/others
3. Tolerance for differences of opinion
4. Ability to reach out to others
5. Motivation and sense of commitment
6. Ability to cope with stress
7. Attitude towards children
8. Ability to make independent judgments
9. Appropriate expression of feeling
10. Understanding of the program

(See interview rating scale and clinical rating scale, Appendix II.)

Candidates who achieved the highest composite ratings are generally accepted for the program. Although a careful selection will provide an excellent group of trainees, it cannot always guarantee total success. Thus, a fourth selection phase was set up as a safety device which consisted of a six-month trial period for certain candidates about whom there were some uncertainties regarding their suitability in the field of child care.

Target Populations for Candidates

The target populations for the Associate of Arts training program are high school students within commuting distance of the participating colleges and, in general, those high school populations from which the college draws its student population.

The target populations for the Bachelors and Masters Degree programs are the various junior colleges and universitites similar to those from which the participating academic institutions draw their student population.

Trainees - Recruitment Methods

Not everyone is suited to be a Child Mental Health Specialist. A broad spectrum of special characteristics is required. In order to be able to have an effective selection procedure, the recruitment of sufficient numbers of applicants is a crucial necessity. Thus, an optimum recruitment program results in at least three applications for every training slot. The recruitment procedures in the present training program consisted of information concerning the program in the college or university catalogue, knowledge of the program by the academic counselors, press releases to school papers, local newspapers, radio and television stations. In addition, brochures were printed describing the training program and mailed to these and other appropriate sources. These were also handed out by trainees and staff at visits to local colleges.

Trainees in the Program

Although it was planned that trainees would be recruited through local high schools, the California College and University system, and from selected sources across the country, only 10 percent indicated that they learned of the program at college. Twenty percent of the trainees indicated that they learned of the program by either visiting the Children's Center at Camarillo, or by working or volunteering at the Center. Another 20 percent responded that they learned of the program from friends or relatives who were either employed at the hospital or participating in the training program. Approximately 40 percent learned of the program from newspapers or journal articles, either directly or from relatives and friends. The remaining 10 percent learned of the program from other sources.

There are currently (1976-1977 training year) no Associate of Arts trainees; forty-three Bachelor Degree trainees, several of whom are Associate of Arts program graduates; and twenty-nine Master Degree trainees, nine of whom are graduates of the Bachelor Degree program.

Since a specific selection rating scale had been used in selecting students, the most significant differences between those accepted and those not accepted was the composite rating score in the ten areas discussed in the previous section which were thought to be most important in predicting success in the training program.

Research on Trainee Selection

Although no systematized research has been undertaken to evaluate the trainee selection procedure, there are a number of indices which assist in the evaluation of

the procedure. One of these is the fact that only two students were asked to terminate the training program during the first six trial months of the program and that only eight dropped out of the three training programs. Another significant index of the success of the selection procedures is the consensus among employers that the program graduates were excellent in terms of clinical competence, job preparation, and overall job performance. The majority of employers who are extremely satisfied with the work of the graduates indicated that they would prefer to hire them if positions were available (59).

RESOURCES - PARTICIPATING STAFF

The academic experiences of the Child Mental Health Specialist is an interdisciplinary one. Students are taught by staff drawn from medicine, psychology, social service, nursing, speech pathology, and education. Wherever possible, they consisted of practicing clinicians in various participating child facilities. This was especially true for the Masters and Bachelors Degree programs. In the Associate of Arts Degree program more staff employed by the academic institutions were used. The amount of time which each staff member devoted to the training program depended on the number of course units for which the staff member was responsible.

Because a deliberate effort had been made to dovetail the academic component with the clinical component, staff from the clinical training facilities were recruited as much as possible for the instruction of academic courses.

Contributions of Clinical Staff

Clinical staff consisted mostly of mental health personnel from the Camarillo Children's Treatment Center and a number of practicing clinicians employed by the various participating community centers. These staff were responsible for the scheduling of activities for the trainees, for the supervision, consultation, and discussion periods. Valuable innovations in the training of the Child Mental Health Specialist are:

1. Training courses in psychodrama in which the trainees act out their feelings and awareness of what is going on in them during the training and their interaction with the children and staff

2. Family therapy seminars
3. Seminars in family psychodynamics
4. Seminars in psychodynamics of child development
5. Seminars in group psychodynamics

Special Skills of the Training Staff

One of the reasons for the success of the training program was the daily experiences of the trainees working with both children and staff. The program was indeed fortunate to attract an interdisciplinary teaching staff who were both experienced teachers and clinicians. All were professionals from medicine, psychology, social service, nursing, speech pathology, special education, etc., who were well trained and versed in working with both normal and problem children. Thus, because of the active clinical involvement of the training staff, they were able to share experiences with the students and relate these to academic theory.

Another special skill of the training staff was that they were able to accept the students on a professional level thereby greatly facilitating the learning process.

Roles and Contributions of Consultants and Advisory Body

Advisory bodies included the association of Parents and Friends of Mentally Ill Children, Inc.; the Camarillo-Neuropsychiatric Institute Research Center; and the faculty at California State University at Northridge.

The consultants included the clinical staff at the Camarillo Children's Center; Dr. Itamar Yahalom, Training Anaiyst; Dr. Stanley J. Leiken, Child Psychiatrist; Dr. Alcon G. Devries; Dr. Jerome Beker, of the editorial staff of the Child Care Quarterly; Dr. Russell G. Herron, Educator; and members of the Board of Parents and Friends of Mentally Ill Children, Inc. The individual persons were asked to act as consultants because of their expertise in different areas significant to the project.

RESULTS OF THE EVALUATION OF THE PROGRAM

The independent evaluation of the program by the UCLA Center for the Study of Evaluation (60) showed that the program produces the following positive results:

1. Graduates and trainees are developing a clear sense of competence in areas of child mental health care.

2. Graduates and trainees reported that they have developed attitudes that will assist them in the implementation of their duties in a child mental health care framework.

3. Staff and trainees agree that a practical orientation is provided by the program.

4. Staff and trainees tend to agree that team participation is fostered.

5. In general, distinctions and self-assessed competencies among the three degree levels of program hold true with clearest differences between the Associate of Arts and Master levels.

6. The provision of a mechanism for upper mobility in the child mental health field.

7. Trainees do have the opportunity to work in a variety of settings and to try out and verify tactics for themselves.

8. Employers report favorable comparisons of graduates in terms of clinical competence with nongraduates.

In addition to the above results, certain other positive outcomes were apparent to the evaluators. One of these was that the philosophy of the training program is diffused to staff who are not directly involved in the training program. Another outcome showed that staff report that they are both stimulated and kept professionally current as a function of the training program. A third outcome indicated that as a result of the active trainee participation in clinical activities, there was a reduction in staff/patient ratios at the training site which resulted in an increase in the quality of care.

A fourth outcome showed thar the participation of the trainees motivated the staff to update and improve their own competencies. Additional findings of this evaluation study are discussed in the section on assessment.

The evaluation also points out certain weaknesses of the present operation of the program. These include:

1. A lack of definition of desired program outcomes ("operationalized domains of competencies should be identified and clear performance indicators applied to assessing program effectiveness").

2. There should be a strengthening of relationships between degree-granting institutions and the training program ("more active interest in the training program by the colleges would be desirable").

3. There are limitations on student stipends which constrain the trainee population to those who can afford to devote full time to the program.

4. There seems to be a lack of consensus about program goals and means of achieving them.

5. There is inadequate orientation to the program for clinical staff, academic personnel, and trainees.

The facilitation or specification and consensus on program objectives could be met by supporting research that would permit the systematic assessment of needs. Various activities involving the planning of the integration of the academic and clinical components of the program by the total group at the beginning of each new training year should be developed to aid in achieving consensus. Consideration also should be given to the development of measures for assessing actual as well as perceived competencies. Such measures might involve simulations to assure that trainees meet minimal standards of performance.

Additional modifications in the program are proposed in order to alleviate the weaknesses found by the Evaluation Center. The first one is a proposed survey of both staff and trainees to assist in a more precise clarification of the various domains of competencies the trainees should achieve at the end of their training. The survey would include the definition of specific objectives in terms of either competencies or performances of both respective academic courses and clinical experiences.

The relationship between degree-granting institutions and training program is a difficult area to assess. In general, relationships would appear to be at least as good as can be expected and may even be better than the average relationship between academic institution and individual institutional programs. For instance, at California Lutheran College the Associate Dean supervises the academic program and visits the program once weekly and has his representatives sitting in on the training committee meetings. In addition, special meetings with the college are held to iron out problems. At the California State University at Northridge the Head of the Child Development Department is the coordinator between the University and the nearby San Fernando Valley Day Treatment Center. Additional relations, however, could be established by yearly reports to academic faculties, administration, and staff and student periodicals.

The lack of orientation on the part of the clinical staff at the time of the evaluation was not surprising in view of the fact that the Camarillo Children's Treatment Center was in a state of change at that time with many staff including experienced supervisors and administrator turnovers. It was significant to note that, notwithstanding the many staff changes, the training program of the Child Mental Health Specialists was recognized as being instrumental in providing stability, reliability, and continuity for the treatment of the children at the Children's Center.

Certain conclusions were drawn by the evaluation study with respect to the strength of the overall operation of the training program:

1. Attempts to integrate the clinical and academic components is feasible and approaches success.

2. The multidisciplinary experience of the training staff is seen as a positive feature of the program.

3. The implementation of the program is in a large measure as it was planned. In fact, deviations of the implementation are generally justifiable results of staff responsiveness to student suggestions and of needs for flexibility to unanticipated constraints.

It was noted in the evaluation that a special study should be devoted to the problem of developing sufficient professional recognition to program graduates. This recognition of the Child Mental Health Specialist may come from the state as well as from a professional organization of graduates and others with similar competencies.

In order to determine the effects of the site and personnel on the implementation of program concepts, it was felt that attempts at small-scale replication at one or more sites other than the present one should be considered. Recruiting procedures for trainees should be augmented.

It was clear that there is a need for programs at all three degree levels. The evaluation report suggested that further study be given to this. Consideration might also be given to affiliations with other academic institutions, especially with state-supported institutions, in order that tuition may be kept relatively low. The final comment of the report stated that consideration should be given to a longitudinal investigation of program effects, particularly if the training model is thought to be replicable.

It should be noted that a further evaluation of the program was made one year later. This evaluation showed that appropriate modifications in the program had been

instituted successfully in most of these areas about which the first evaluation had been critical. It is apparent, therefore, that future programs need to have a feedback procedure built into them.

Employer Evaluation of Child Mental Health Specialists

One aspect of the evaluation included a survey of employers of graduated Child Mental Health Specialists at the various degree levels. The purpose of this survey was to obtain an evaluation from the employers regarding the program graduates, especially in comparison with nontrained staff working in similar positions.

The overall consensus among employers of graduates is that they are excellent in terms of clinical competence, job preparation, and overall job performance. In fact, they rate graduates' overall job preparation, repertoire of clinical skills, and knowledge of children as being more comprehensive than nongraduate employees who are performing the same types of functions. Graduates, it is noted by employers, have a higher level of self-competence, a greater ability to deal with frustration, a higher level of job performance, a greater ability to communicate with a child on his own level, and are better able to evaluate a child's progress and the worth of their own efforts. The majority of employers seem to be extremely satisfied with the work of the graduates and indicated that they would prefer to hire Child Mental Health Specialist graduates if positions are available. In fact, no negative comments were received. The pattern of responses from employers of program graduates indicates there is a greater differentiation between graduates and their nongraduate counterparts when employed in a nonclassroom setting. When they are functioning in a classroom setting, graduates

rate either equivalent to or somewhat higher than their nongraduate counterparts in these areas. The evaluators of the program make the following conclusion: "It would appear then that the training program, from a standpoint of employers surveyed, has prepared the Child Mental Health Specialist for a successful and satisfactory job performance."

ASSESSMENT

The Child Mental Health Specialist Training Project received special support in the area of project assessment from the National Institute of Mental Health which provided funds to the University of California at Los Angeles, Center for the Study of Evaluation, to conduct an evaluation of the training program. The purpose of the evaluation was to document the salient characteristics of the training program and its effects on program trainees and graduates. A complete report of this study has been attached (see Appendix III). The following steps were taken prior to instrument development:

1. An extensive review was done of documents describing the Camarillo program. This review included:
   a. an analysis of the academic curriculum and available clinical experiences
   b. an examination of available program records, and
   c. exploratory interviews with administrators, staff, and trainees selected on the basis of availability
2. The determination of program goals and related evaluation questions
3. The identification of relevant and available data sources
4. The consideration of alternative methods of data collection

The means for data collection included interviews, self-report questionnaires containing five-point rating scales, and a review of relevant records. The self-report questionnaire for the trainees included such background information as their educational and employment history, marital status and age, as well as questions referring to how

they learned about the training program at Camarillo and why they had chosen it. Another self-report questionnaire asked trainees to indicate on a five-point scale what they felt their level of competency was in a series of skill and knowledge areas. The trainees were also asked to indicate how characteristic each trait and attitudinal statement was of themselves. In addition to rating their own competence, the trainees also were asked to assess the adequacy with which each area was covered by the training program. A final set of questions was aimed at eliciting opinions about:

a. the quality of the training program

b. trainee satisfaction with specific program components

c. trainee satisfaction with specific aspects of the program

d. trainee satisfaction with the overall program

e. the degree of similarity between the three different degree levels

f. the success of the program in achieving its goals

g. the clinical atmosphere in which the trainees worked and

h. trainee support of the training program

i. strengths and weaknesses of the program

j. consequences of the program

k. unanticipated outcomes of the program

l. recommendations for change in the program

m. who or what was most responsible for learning outcomes

n. differences between trainees and psychiatric technicians

o. the trainee's conceptualization of his or her role as Child Mental Health Specialist

The evaluation study also investigated what an IDEAL training program leading to a child mental health degree should include. The various responses to the questions were quantified by means of three-point and five-point rating scales.

The same set of skill and knowledge competencies and personal attitudes and characteristics as those for the people in training were included in the questionnaire for those who had graduated from the three programs. In addition to rating their competency in each skill and knowledge area listed, however, program graduates also were asked to indicate how adequate they felt program coverage was for each area listed and how often they use each on their job. Personal attitudes and characteristics were assessed through a series of statements in which they were asked to describe how true these were when they first started the program and how true these were at the time that they completed the questionnaire. They were also asked to indicate the extent to which participation in the program could account for any change. Selected response items, similar to those found in the final trainee questionnaire, were more limited in scope for the graduates since it was felt that they might not accurately remember all aspects of their training experience. The selected items included related to:

a. overall training as job preparation

b. current employment experiences

c. current availability to work

d. current job prospects

e. work load of the trainee

f. satisfaction with staff feedback and responsiveness and

g. the importance of being a graduate of the Child Mental Health Specialist Training Program in gaining their employment

These questions, too, were asked on a five-point rating scale. The set of questions relating to the definition of an ideal Child Mental Health Specialist Training Program which had been included in the trainee questionnaire section was also included in both the graduate and staff questionnaires. The same list of skill and knowledge competencies used on the trainee questionnaire was also used on the staff questionnaire. Staff were asked to rate the competence of the majority of Associate of Arts Degree trainees, Bachelor Degree trainees, and Master Degree trainees in a variety of areas. A section regarding a number of specified personal attitudes and characteristics also were included. Five-point scales were developed to assess responses to:

a. the overall quality of the program

b. the quality of specific aspects of the program

c. training as job preparation

d. overall knowledge of the academic and clinical components of the training program

e. the success of the training program in reaching goals and

f. staff work load

In addition, there were open-ended questions which referred to:

a. strengths and weaknesses of the program

b. goals of the program

c. various differences between psychiatric technicians and trainees

d. effects of the program on their philosophy or practice of child care

e. unanticipated outcomes

f. differences in program content and the need for three different training levels

g. support of the training program

h. suggestions for changing or adding to current trainee experiences (academic and clinical)

i. examples of course criteria

j. conceptualization of their role as a trainee supervisor

In addition to questionnaires for trainees and graduates, a questionnaire was developed to survey a small sample of staff and administrators regarding the curricular strengths and weaknesses of each degree program and essential content areas.

Despite the few program graduates and few available employers, a separate questionnaire was developed to obtain at least an indication of operational outcomes of the program. In order to ensure the probability of an immediate return, these questionnaires were limited to two pages. Graduates also were rated by means of a five-point scale on a small sample of essential skill and knowledge competencies and personal attitudes and characteristics. In addition, they were rated in terms of:

a. their overall job preparation

b. their job performance

c. their observed competencies

d. their professional abilities

e. the degree of similarity between graduates and others performing the same job

Data Collection Procedures

All trainees enrolled in the September 1975 training program received both the background and the baseline questionnaire. The purpose of the evaluation study

and the role the trainees would play in it was explained to them by the director of the evaluation project. All trainees were requested to complete and return the questionnaires to the training program coordinator within a week. A final questionnaire was administered in mid-January of 1976. This was done to provide time for trainees, especially the new ones, to become familiar with the program.

Program graduates received both questionnaires and interviews. They were given a questionnaire at the close of each interview by the project evaluator during mid-October and again in December, 1975, with a request to return it within two weeks.

Individuals from the training program representing different disciplines and different roles in the program received a staff administrator's survey regarding specific aspects of the academic curriculum. Individuals thought to represent organizations employing program graduates received, completed, and returned a two page selective response questionnaire.

A number of trainees and program administrators also were interviewed, especially in relation to:

a. strengths and weaknesses of the training program

b. further clarification and definition of program goals and desired outcomes

c. observed differences between psychiatric technicians and Child Mental Health Specialist trainees

d. observed differences among trainees at the different degree levels and among trainees at the same degree level

e. expectations of staff administrators and trainees

f. satisfaction with available academic and clinical experiences and

g. latitude given course instructors in designing the courses they instruct

These interviews were conducted in order to gain a greater understanding of the program. Graduate and trainee interviews usually lasted about fifty minutes. All of the graduate interviews were conducted in person. Half the trainee interviews were conducted in person; but, because daytime scheduling was difficult to arrange, half of trainees had to be interviewed by telephone. Thirty-three clinical supervisory evaluations were available as part of the regular program procedures. Those interviewed were selected at random and determined by the time available. Sixteen courses taught by nine instructors during the Spring 1975 and Summer 1975 semesters were evaluated and summarized. The courses evaluated represented all three degree program curricula and were reviewed on the basis of availability. Grade distribution samples were taken from forty-one courses offered from the Fall 1973 quarter through the Fall 1975 quarter.

Data Analysis Procedure

Ratings of the trainee and staff questionnaires were keypunched and summarized by computer. Quantitative responses of the employer and graduate questionnaires were hand tallied. Open-ended responses on questionnaires and interviews were abstracted. Since data were obtained from small samples, comparative statistical routines would provide only marginal useful information. As a result, it was felt that comparative statistical analysis of the data would be inappropriate because between group comparisons would not be meaningful. Instead, the focus was on the range, frequency, patterns, and variability of responses on particular item sets.

Review of the Records

The majority of grades were either A's or B's with only rare occurrences of C's, D's, and F's recorded. Statistics was the course which appeared to give trainees the most difficulty. The widest distributions were in the Summer 1974 semester. Child Development I also appeared to be more difficult for students than many of the other classes. Supervisors were rated excellent to good. Most evaluations that were reviewed indicated that the trainees were satisfied with the level and quality of supervision provided. Suggestions for change were limited to provisions for more structure and more guidelines regarding the goals and expectations. Likewise, a majority of instructors were rated as either excellent or good. Some were being rated fair. Similar ratings were given to the courses they taught. There was general agreement among most trainees that all course objectives were clearly stated, course lectures and materials were clearly laid out, instructors were able to convey course content, and that theory and clinical practice were adequately integrated.

Although many of the courses used term papers instead of tests for determining grades, most trainees were satisfied with the methods employed of testing their knowledge of the course content. The trainees felt that the course material presented was total in scope and that there was sufficient opportunity to participate in class. Suggestions for improving or enhancing the courses included providing a variety of course material presentations, arranging more field trips and providing more structure. Courses about teaching methods received lower ratings because it was felt that the course instructors had no perspectives and not enough firsthand experiences to relate to the class

at a practical level. These teachers were regular academic staff from the affiliated colleges and not clinical staff

The report which details the total evaluation study, instruments, and results is shown in Appendix III.

DISCUSSION

Without any doubt, the Child Mental Health Specialist Training Project has been a tremendous success. This is attested to by the ready acceptance of both the participating academic and clinical institutions and facilities, the participating staff, the trainees, the innumerable requests from potential trainees, and the many inquiries for information regarding the project and requests for reprints of articles describing the program as well as the interest by the news media about particulars of the program. The main fact is that Child Mental Health Specialists can be very successfully trained by incorporating both academic and clinical training. The second important fact is that specific job-oriented training can be combined very successfully with simultaneous academic training. The third fact is that training programs can easily be adopted to various academic institutions as was shown by the acceptance of the respective programs by the three academic institutions in the present project. The fourth finding is that it is possible to define the relevant academic courses and their contents as well as the applied experiences needed for a well-balanced training program.

EMPLOYMENT POSSIBILITIES FOR CHILD MENTAL HEALTH SPECIALISTS

Since graduates from the Child Mental Health Specialist Training Program have received degrees from recognized academic institutions, they receive ready acceptance of their qualifications for those positions for which they are eligible. Because child care encompasses many areas of close to one-third of our total population, potential employment opportunities are considerable. The level of pay depends to a great extent on the pay schedule of other personnel in related positions or personnel with the same level of qualifications. Because of the nearly total absence of trained child care treatment personnel, the graduate Child Mental Health Specialist appears to be able to command a slightly higher remuneration than might be expected in other areas with similar levels of training.

Positions for which the various graduates qualify at the respective levels of training are shown in Tables 10, 11, and 12, together with the corresponding responsibilities.

TABLE 10

Employment Possibilities for Graduates
from the Associate of Arts Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
State Mental Hospitals, Children's Facilities, Residential Settings, Group Homes, and Day Treatment Centers	-child care work activities -group activities -plays, games -one-to-one relationship -recreational activities -teach developmentally and otherwise disabled children self-care: feeding, dressing, washing, bathing, toothbrushing, time concept, hours, days, months, years, basic home economics -safety rules -outings to community facilities, to parks, to stores -play therapy -behavior therapy	Nursery Schools	-help design and implement nursery school program -teach preschool children -affective interaction -group and individual activities -encourage peer relationship -plays, games
		Head Start	-teach parents of socially disadvantaged children educational and mental health principles -program of stimulation through parent education -emotional support for mothers -home visits -support of families in their homes -assist in developing intergenerational activities in family
Special Classes in Mental Health Facilities and Public Schools	-assistant to teacher -tutoring -affective interaction -controlling through appropriate discipline		
Satellite Homes	-surrogate parents to (continued)	Community Mental Health Centers	-assistant to family in (continued)

continued

TABLE 10 continued

Employment Possibilities for Graduates from the Associate of Arts Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Satellite Homes (continued)	four severely developmentally disabled or mentally ill children	Community Mental Health Centers	distress or crisis with homemaking -provide surrogate parenting in child's home -provide day caring in neighborhoods for working mothers
Foster Homes	-foster parents		
Normal Homes	-homemaking -support families in distress -affective interaction with children in their own homes, in the neighborhoods	Public Schools	-teaching assistant -individual tutoring -affective interaction with children -apply mental health principles in classroom activities -liaison between school and parents -assist in recreational activities and outings

TABLE 11

Employment Possibilities for Graduates
from the Bachelor of Arts/Science Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
State Mental Hospital Children's and Adolescent Treatment Centers	-child care work with children -group leadership and one-to-one work -participation as a milieu therapist -charting and reporting behavior of children and adolescents -behavior therapy in one-to-one relationship and with groups of adolescents -life-space therapist -arts and crafts activities -planning and designing sports and recreational programs for adolescents	Nursery School Director; Day Care Center Director	-plan, design, and implement program to meet the educational, social, and emotional needs of preschool children -affective interchange with individual children, in a one-to-one relationship, who need special attention
Group Home	-as above -assistant program coordinator -research assistant	Head Start	-plan, design, and implement program for socially disadvantaged young preschool children with involvement of parents through home visits -program of stimulation through parent education
Classroom Activities in a Mental Health Setting	-assist the teacher in both implementation and planning of school activities (continued)	Children and Adolescents in Difficult Home Situation with Both or One Parent Only	-after-school and weekend activities -set up recreational activities for small groups in neighborhoods -provide emotional (continued)

continued

TABLE 11 continued

Employment Possibilities for Graduates from the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Classroom Activities in a Mental Health Setting (continued)	-assist the teacher with specific special education tasks -develop means of controlling the children's behavior -one-to-one tutoring of difficult adolescents -limit setting and appropriate non-punitive discipline -behavior modification techniques -conducts fine motor program and gross motor program as part of the educational program of children and adolescents	Children and Adolescents in Difficult Home Situation with Both or One Parent Only (continued)	support to one-parent home -family counseling -sports activities
		Services to Violent Families	-provide emotional support -application of social/psychological principles to increase the policeman's effectiveness in handling such problems -help parents deal with underlying fear, hurt, and frustration -educate parents to the psychodynamics of child development -educate parents to the use of nonpunitive measures
Speech and Language Laboratory	-evaluation -testing -behavior modification -group and individual sessions -social skills training -speech therapy with individuals and small groups -dealing with receptive language skills and expressive skills	Police Station Truants from home or school, for boys and girls	-improve police/community relations, especially in minority group problems (continued)

continued

TABLE 11 continued

Employment Possibilities for Graduates from the Bachelor of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Probation Department	-individual and group counseling -educational tutoring -mechanical and industrial skills development -vocational guidance -camp activities -backpacking	Police Station (continued)	-sensitize police to social/emotional problems -involvement of boys and girls in YMCA recreational and sports activities
		Satellite Home Parents	-provide psychological parenting to normal children who need to be separated from their own homes and parents because of violence, abuse, or other traumatic home environments
Youth Authority	-individual and group counseling -tutoring -mechanical and industrial skills development -vocational guidance		
Public Schools	Special Education: -help plan, design, and implement classroom activities -help control children -affective interchange with children who need special attention -tutoring individual children -teacher's assistant	Community Mental Health Center	-participation in preventive child abuse programs

TABLE 12

Employment Possibilities for Graduates
from the Master of Arts/Science Degree Training Program
for Child Mental Health Specialists

INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Children's Facilities in State Mental Hospitals	-group leader -life-space therapist -play therapist -cottage assistant coordinator -cottage coordinator -assistant program director -program director -planning, designing, implementing, and supervising treatment programs -research assistant	Day Care Centers	-plan, design, and direct program
		Head Start	-plan, design, and develop program -emotional support for parents of socially disadvantaged, young preschool children -program of stimulation through parent education -involve parents through home visits
Youth Authority	-group leader -group therapist -life-space therapist -unit coordinator -individual and group counseling -vocational guidance -develop arts and crafts programs -develop industrial and vocational skills	Therapeutic Nursery Program	-plan, design, and implement therapeutic nursery program
		Children's Hospital in the Community	-psychological care of children and adolescents to master problems arising from medical or surgical intervention
Group Homes in Communities	-group home coordinator -group therapist (continued)	Developmental Disability Clinic in Pediatric Hospitals	-participating member in team approach to (continued)

continued

TABLE 12 continued

Employment Possibilities for Graduates from the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Group Homes in Communities (continued)	-family counseling -collaboration with community placement facilities	Developmental Disability Clinic in Pediatric Hospitals (continued)	bring out the potential in disabled or vulnerable children from early infancy to preschool age
Day Treatment Centers	-plan, design, implement, and supervise arts and crafts activities -special education programs and establish liaison with public schools	Well-Baby Clinic	-guidance and training of mothers in principles of psychodynamics of child development -emotional support for mothers
Probation Department	-work with dependent and delinquent children -design, develop, and implement rehabilitation programs -camp activities -backpacking -prevocational training -preparing for employment possibilities -liaison with protective workshops in the community	Community Mental Health Centers Obstetric Departments in Hospitals	-member of team in prenatal guidance of mothers and education in infant development
		Community Mental Health Centers	-infant stimulation and psychodynamics in relationship between mothers and infants -participation in preventive child abuse program through parent education

continued)

TABLE 12 continued

Employment Possibilities for Graduates from the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
Community Mental Health Centers: Social Work Associate	-continuing care services -case work with agencies -placement of children in foster homes	Services to Violent Families	-provide emotional support -application of social/psychological principles to increase the policeman's effectiveness in handling such problems -help parents deal with underlying fear, hurt, and frustration -educate parents to the psychodynamics of child development -educate parents to the use of nonpunitive measures
Satellite Homes	-parenting -supervision of other Satellite Homes -training surrogate parents and foster parents		
Child Abuse	-emotional support to parents -parent education and teach nonpunitive discipline -family therapy	Police Station Truants from home or school, for boys and girls	-improve police/community relations, especially in minority group problems -sensitize police to social/emotional problems -involvement of boys and girls in YMCA recreational and sports activities
Public Schools: Special Education Classes	Special Education: -teacher -plan, design, and implement classroom activities -plan, design, and direct special education classrooms		

continued

TABLE 12 continued

Employment Possibilities for Graduates from the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
		Satellite Home Parents	-provide psychological parenting to normal children who need to be separated from their own homes and parents because of violence, abuse, or other traumatic home environments
		Public Schools	-teach normal children -apply mental health principles to process of education -teach students in parenting and functional child development -apply theoretical knowledge to daily living conditions: in homes, day care centers, Head Start, nursery schools, Satellite Homes, day treatment centers, and residential treatment centers
		Public School Principal	-collaborate with (continued)

continued

TABLE 12 continued

Employment Possibilities for Graduates from the Master of Arts/Science Degree Training Program for Child Mental Health Specialists			
INTERVENTION		PREVENTION	
Employment Possibilities/Situations	Activities	Employment Possibilities/Situations	Activities
		Public School Principal (continued)	mental health professionals, designing curriculum and applying child mental health principles, and using process orientation in classroom activities -involve parents in curriculum development -involve students in supportive roles to families in various community activities -involve students in intergenerational activities involving all ages in the life cycle, including homes for the elderly, and disabled and healthy young children

The wide variety of employment opportunities is already evidenced by some of the people who have graduated from the program. For instance, the following positions have either been offered to graduates or have been accepted by them:

- group home coordinator
- dorm supervisor
- child care worker
- Satellite Home parents
- special education teacher
- director of California Learning Center in Ventura
- mental health clinic program worker
- junior high school teacher
- consultant to an academic and residential program
- social work associate
- director of day care center
- special education teacher
- program worker with developmentally disabled
- Child Mental Health Specialist in a residential treatment program
- early childhood education specialist
- adult education teacher
- teacher in developmental disabilities program
- coordinator and liaison person between the community mental health and school system

- youth counselor and group leader in the Department of the Youth Authority
- director of a Saturday school college program
- associate in private practice with clinical psychologist
- research assistant
- Ph.D. in clinical psychology

ADDITIONAL TRAINING NEEDS

Additional training needs which have become apparent are the inclusion of a significant part of the Associate of Arts and Bachelor Degree training program in the training of elementary and high school teachers. Teachers work with children five or more hours per day during the school year. They deal with the whole range of problems in children. Unfortunately, their training in dealing with all nonintellectual developmental aspects of children, especially in recognizing maladjusted conditions and behaviors, is minimal or nonexistent. As a result, their ability to deal with problem children is badly lacking. The inclusion of a solid core of training in child care would considerably lessen the frustrations which teachers experience at present in dealing with a problem child or emotionally disabled child. An ability on the part of the teacher to provide emotional support to these children would, to a very significant degree, assist in the reduction of children who need to be seen by specialists. If teachers are trained in the psychological as well as the intellectual aspects of the child, the communication gap presently existing between teachers and child care personnel, between educator and child mental health professional, would vanish. Unfortunately, the teacher is generally not yet trained in the psychological aspects of the child, while the child care worker and the mental health professional is not trained in the educational aspects. The prototype Child Mental Health Specialist program now is attempting to remedy the latter deficiency by providing this option in the Master Degree training program (see Table 15, Option II). We also need to remedy the hiatus in the training of the teacher by mainstreaming child mental health into teacher training.

It should be recognized, of course, that the aim is not to train the teacher as a clinician. What is important is that the teacher is trained to be aware of the psychological aspects of the child and of the process aspect that takes place between the child or student and other children or students and other disturbed children, between student and teacher, student and supervisor, etc. The training in this "process," therefore, will create insight and coping ability and understanding of the psychological dynamics which take place. Similarly, Child Mental Health Specialists need to be trained in awareness of the intellectual aspects of the children. We need to train personnel both for the future and now, teachers who are skilled in prevention and early intervention, and clinicians--Child Mental Health Specialists--who are skilled in treatment as well as in prevention and early intervention.

If a particular training program is set up as an independent school within an academic institution, the length of training could be attuned to whatever time would be necessary to provide the optimum amount of training at whatever level. It appears, however, that it is neither necessary nor desirable to encourage the development of special schools. It has proved to be quite feasible to provide the training programs within existing academic and clinical structures. As such, the length of the program needs to be coordinated with the existing system. Fortunately, this has proved to be quite feasible. In addition, a successful training program needs to consider existing career ladders. The present program appears to fit in well and, in fact, provides for a number of options at each of the different levels, thus, making it a highly desirable program from which to graduate.

It is difficult to evaluate whether it is possible to provide the same type of training for part-time students such as evening and weekend students, or summer school

students. Summer training would appear to be a very distinct possibility, especially for teachers. This might be a very profitable avenue to pursue, especially for the purpose of providing existing teachers with additional skills. The part-time training of Child Mental Health Specialists would seem to be more difficult but not necessarily impossible. The difficulty basically concerns the availability of staff to provide clinical supervision since the staffing patterns in most of the child care institutions is best during the daytime and greatly reduced during evenings and weekends.

The greatest need to draw trainees from other than the present population appears to be to encourage regular school teachers and special education teachers to take parts of this program, especially the Masters Degree level program. It was clear from the large number of applications for the few available positions at the various levels that there is a great deal of interest among young people to work with children.

FINAL PROTOTYPE CURRICULUM FOR THREE LEVELS OF CHILD MENTAL HEALTH SPECIALISTS

Now that seven years of training Child Mental Health Specialists have been experienced, it is possible to suggest ways in which the various programs could be enhanced. Some areas were not covered while others were stressed too much. The suggested modifications (Tables 13, 14, and 15) have as an aim to provide a continuity of training in the three degree levels, Associate of Arts, Baccalaureate, and Masters (AA, BA/BS, MA/MS), to prevent repetition, and to integrate the three programs with career ladders and opportunities for branching into other professional areas or directions. In addition, the final prototype curriculum takes account of training procedures in other countries and other parts of the United States, and a survey of training needs for child care staff in the complete spectrum of child care facilities dealing with both normal and disabled children (61). An outline of the course content of the three final prototype curricula is shown in Appendix I.

TABLE 13

Final Prototype Curriculum for the Associate of Arts Degree Training Program for Child Mental Health Specialists

YEAR 1 -- SEMESTER 1

Course Units		
1.5	1.	General Psychology (A)
3.0	2.	Introduction to Normal Child Growth and Development, Child Psychology
1.5	3.	Problems of Childhood (1)
		- Mental Retardation
		- Emotional Disorders
1.5	4.	Problems of Childhood (2)
		- Behavior Disorders
		- Antisocial Behavior
.75	5.	Child Health
.75	6.	Methods of Child Care
1.5	7.	Recreation--Crafts, Activity
.75	8.	Records and Reports
.75	9.	Child Discipline and Management
1.5	10.	The Family
4.5	11.	Practicum--Two days per week
18.0		

continued

TABLE 13 continued

YEAR 1 -- SEMESTER 2

Course Units		
1.5	1.	General Psychology (B)
1.5	2.	Introduction to Sociology and Anthropology
1.5	3.	Problems of Childhood (3) - Disadvantaged - Physically/Neurologically Handicapped - Treatment
1.5	4.	Learning Disabilities--Assessment and Remediation
.75	5.	Behavior Techniques/Management--Theory
1.5	6.	Behavior Techniques/Management--Special Problem Areas
1.5	7.	Group Management
1.5	8.	Communication--Reporting and Recording
.75	9.	Household Management Skills
4.5	10.	Practicum--Two days per week--Supervised Participation in the Nursery School
1.5	11.	Seminar--Options Including discussions of practicum experiences, understanding of self, and sensitivity training
18.0		

continued

TABLE 13 continued

YEAR 2 -- SEMESTER 1

Course Units		
1.5	1.	Child Psychology/Psychiatry (A)
1.5	2.	Group Dynamics (A)
1.5	3.	Problems of Childhood (4) - Attitude towards Mental Illness and Mental Retardation - Mental Disorders in Adolescence
1.5	4.	Adolescent Psychology
1.5	5.	Education Psychology/Education Techniques
1.5	6.	Nursery School Program and Kindergarten Program
1.5	7.	English Language and Children's Literature (A)
1.5	8.	Speech and Language--Assessment and Intervention
4.5	9.	Practicum--Two days per week
1.5	10.	Seminar--Options Including discussion of practicum, experiences, understanding of self, and sensitivity training
18.0		

continued

TABLE 13 continued

YEAR 2 -- SEMESTER 2

Course Units		
1.5	1.	Child Psychology/Psychiatry (B)
1.5	2.	Group Dynamics (B)
1.5	3.	The Preschool Child
1.5	4.	Problems of Childhood (5)
		- Drug/Alcohol Addiction
		- Hospital and Hospitalization
1.5	5.	Crisis Intervention
1.5	6.	Children's Classroom Instruction
1.5	7.	English Language and Literature for Preadolescents and Adolescents (B)
1.5	8.	The Juvenile and the Justice System
1.5	9.	University Course
4.5	10.	Practicum
18.0		

TABLE 14

Final Prototype Curriculum for the Bachelor Degree Training Program for Child Mental Health Specialists

YEAR 3 -- SEMESTER 1

(for Years 1 and 2, see Table 13)

Course Units		
1.5	1.	Introductory Biology (A)
1.5	2.	Personality (A)
1.5	3.	Child Development Treatment and Services
1.5	4.	Learning Disabilities (A)
1.5	5.	Family (A)
1.5	6.	Philosophy and Religion
.75	7.	Community
.75	8.	Community Resources
1.5	9.	The Dependent Child--Social Work
1.5	10.	Crisis Intervention
4.5	11.	Practicum--Fieldwork
18.0		

continued

TABLE 14 continued

YEAR 3 -- SEMESTER 2

Course Units		
1.5	1.	Introductory Biology (B)
1.5	2.	Personality (B)
1.5	3.	Family (B)
1.5	4.	Learning Disabilities (B)
1.5	5.	Working with Parents of Disturbed Children
1.5	6.	Behavior Therapy
1.5	7.	Introduction to Staff and Diagnostic Conference
1.5	8.	Juvenile Delinquency--Probation
6.0	9.	Practicum--Fieldwork
18.0		

continued

TABLE 14 continued

YEAR 4 -- SEMESTER 1

Course Units	
1.5	1. University Course
1.5	2. University Course
1.5	3. University Option--e.g., Contemporary Systems and Theories
1.5	4. University Option--e.g., Advanced Child Growth and Development I
1.5	5. Counseling: Interviewing (A)
1.5	6. Family Relations
1.5	7. Residential Programs
1.5	8. Psychosocial Studies of the Minority Child
6.0	9. Practicum
18.0	

continued

TABLE 14 continued

YEAR 4 -- SEMESTER 2

Course Units	
1.5	1. University Course
1.5	2. University Course
1.5	3. University Option
1.5	4. University Option--e.g., Experimental Psychology
1.5	5. Clinical Aspects of the Minority Child's World
1.5	6. Counseling (B)
1.5	7. Family Therapy
1.5	8. Advanced Child Growth and Development
6.0	9. Practicum
18.0	

TABLE 15

Final Prototype Curriculum for the Master Degree Training Program
for (a) Child Mental Health Specialists
and (b) Education and Special Education

OPTION I: Masters Degree in Child Mental Health Specialist

YEAR 5 -- SEMESTER 1

(for Years 1-4, see Tables 13 and 14)

Course Units		
3.0	1.	University Course--Thesis
1.5	2.	Crisis Intervention
.75	3.	Basic Life Science
.75	4.	Basic Pharmacology
1.5	5.	Clinical Sciences and Techniques
1.5	6.	University Course
1.5	7.	University Course
1.5	8.	System Theories
3.0	9.	University Course
1.5	10.	Vocational Training
1.5	11.	Practicum Including practicum in specialized treatment facilities and experience in administration
18.0		

continued

TABLE 15 continued

OPTION 1: Masters Degree in Child Mental Health Specialist

YEAR 5 -- SEMESTER 2

Course Units		
3.0	1.	University Course
1.5	2.	Treatment Planning
1.5	3.	Counseling-Interviewing/Crisis Intervention
3.0	4.	Behavior Management--Special Problem Areas
3.0	5.	Program Administration
1.5	6.	University Course
3.0	7.	University Course
1.5	8.	Education and Special Education
18.0		

continued

TABLE 15 continued

OPTION II: Masters Degree in Education with Emphasis in the Field of Special Education

YEAR 5 -- SEMESTER 1

(for Years 1-4, see Tables 13 and 14)

Course Units		
3.0	1.	University Course
3.0	2.	Learning Disabilities I: Reading Procedures Assessment and Remediation
3.0	3.	Learning Disabilities II: Math Procedures Assessment and Remediation
3.0	4.	Methods of Multicultural Education
4.0	5.	Diagnostic Testing
2.0	6.	Field Study: Special Education
18.0		

continued

TABLE 15 continued

OPTION II: Masters Degree in Education with Emphasis in the Field of Special Education

YEAR 5 -- SEMESTER 2

Course Units		
3.0	1.	Language and Speech Development and Disorders
3.0	2.	Behavior Modification Techniques for Multiple Handicapped, Emotionally Disturbed, and Autistic Children
2.0	3.	Organic and Cultural Basis for Severely Handicapped
3.0	4.	Diagnostic and Prescriptive Teaching of Reading
1.0	5.	Field Study
3.0	6.	University Course
1.0	7.	Learning Disabilities III: Motor-Perceptual Procedures
2.0	8.	The Severely Disturbed Adolescent
18.0		

continued

TABLE 15 continued

OPTION II: Masters Degree in Education with Emphasis in the Field of Special Education

YEAR 6 -- SEMESTER 1

Course Units		
3.0	1.	Counseling Exceptional Children and Parents (Individual and Group)
2.0	2.	Psychology of the Exceptional Child (Psychopathology of Childhood)
3.0	3.	Statistics
3.0	4.	Directed Teaching
(or)		(or)
3.0		Field Study: Special Education
1.0	5.	The Dependent Child--Social Work
(or)		(or)
1.0		Juvenile Delinquency--Probation
3.0	6.	University Course
3.0	7.	University Course
18.0		

continued

TABLE 15 continued

OPTION II: Masters Degree in Education with Emphasis in the Field of Special Education

YEAR 6 -- SEMESTER 2

Course Units		
3.0	1.	University Course
3.0	2.	Directed Teaching
(or)		(or)
3.0		Field Study
(or)		(or)
3.0		University Course
3.0	3.	Techniques of Teaching the Severely Handicapped and Working with Their Parents
		(Play Therapy)
3.0	4.	Learning Characteristics of the Developmentally Disabled
3.0	5.	Methods of Research (and)
2.0		Thesis or Project
1.0	6.	Field Study
18.0		

THE EFFECTS OF THE TRAINING PROGRAM ON TRAINEES AND STAFF

In a self-assessment of the skills following the training program, trainees reported that they felt more competent in group counseling skills and in conducting speech and language therapy. Trainees in the first year of the Bachelor's and Master's Degree programs indicated that they felt more competent in assessing learning disabilities than they had at the start of the program. In all instances, trainees in their second or third year of the program tended to rate themselves more competent than the first-year trainees. Second- and third-year trainees also reported a high competence level in behavior management skills, one-to-one counseling skills, parenting skills, communication skills, and crisis intervention skills. Special education skills and diagnostic testing skills were areas for which second-year Bachelor Degree and second-year Master Degree trainees rated themselves highly. Trainees in the Associate of Arts program rated themselves lowest in the special education skills, especially in the assessment of learning disabilities. Students in the second year of the Bachelor Degree program and in the second-year Master Degree program felt very competent in evaluating the services that they can provide as well as assessing their own and other's strengths and weaknesses as Child Mental Health Specialists.

In general, the training program seemed to have more positive effects in the area of the knowledge of early childhood development than it did for later childhood or adolescence. The coverage of listed knowledge and skill areas was indicated as adequate by the majority of trainees. Not all trainees felt comfortable using more than one therapeutic approach. Similarly, not all felt comfortable in a supervisory

role or in suggesting or implementing their own ideas. Trainees in the first-year Master's Degree program and second-year Associate of Arts program usually rate themselves in the midranges in these areas. In regard to the operation of the training program, trainees rated the training as being very successful in achieving its goals; and all reported that they would recommend the program to others interested in a career in the child mental health field. It was also recommended that similar training programs to the present one be established nationwide.

The evaluation reports, however, that this positive disposition seems to be based on a relatively incomplete understanding of the program goals. For instance, one of the goals of the program is to produce a new profession of Child Mental Health Specialists to act as "generalists with an interdisciplinary approach." Only half of the trainees can respond meaningfully when asked what this statement meant. Regardless, most trainees reported that they probably would go on for a higher degree in child mental health.

Certain areas of the program operation were rated as very good to excellent. In such areas as instructors, supervisors, courses, and clinical rotations, trainees feel that they are being exposed to a variety of experiences and that these experiences enable them to work as active and contributing members of the total treatment team. Trainees rate very good to excellent their overall training as preparation for successful job performance in the field of child mental health. Responsiveness of instructors and supervisors seemed most satisfactory. Responsiveness of the administration was also rated as satisfactory, but the variance of responses were greater. There was also general satisfaction with the quality of feedback received from instructors and supervisors, the

relevance of examinations and course assignments to course objectives, and the availabiiity of clinical supervisors for consultation. There is more of a neutral response to these areas, however, among the second-year Associate of Arts Degree trainees than the first-year Master's Degree trainees. Articulation of training responsibilities, desired outcomes, and criteria of mastery of essential course content was inconsistent. Bachelor Degree trainees and second-year Master Degree trainees were more satisfied in these areas than Associate of Arts Degree trainees.

The affiliated colleges were not judged highly in either their understanding of, or responsiveness to the goals of the program. Most of the trainees felt that the clinical experience of the various degree levels are more alike than different. Many, in fact, said that they were very alike. No agreement was found regarding systematic differences in the academic content of the various degree programs. Students indicated that they are generally satisfied with the program the way it is, although some would like to see fewer academic courses and a more manageable and flexible work load. The most often repeated phrase or response when questioned regarding the program and its goals was "to provide the individual with the realistic and practical education and an understanding of the total child so that he or she can use a variety of methods to deal with the different kinds of children and settings."

The trainees felt that there are certain basic differences between trainees and psychiatric technicians. They emphasize, however, that a good psychiatric technician, especially with many years of experience in working with children, is similar to what a good Child Mental Health Specialist should be when he graduates from the program. The differences between these two professions, it is felt, stem largely from their

orientation, role definitions, and understanding of children. Psychiatric technicians have more of a custodial orientation and are trained in the medical model, whereas Child Mental Health Specialists are more treatment oriented and concerned with the "total" child. Psychiatric technicians might share the Child Mental Health Specialist trainee's concern for the child, yet it is felt they do not have the same range of strategies for dealing with children as Child Mental Health Specialists do.

Although there is general satisfaction with the course offerings and the clinical settings available, the trainees indicate that they would like more opportunity to practice counseling skills, crisis intervention skills, program planning skills, play therapy and counseling techniques.

Differences among program levels were attributed to individual differences in maturity, and prior academic experiences in trainees, rather than clinical or program distinctions. The general opinion was that Associate of Arts Degree trainees are being prepared to perform at the line personnel level, whereas Bachelor Degree trainees are prepared to provide counseling and therapy under supervision, and Master Degree trainees are prepared to conduct more in-depth therapy and to teach. All trainees indicated a desire to work in counseling and teaching positions. The type of employment they indicated they would seek upon graduation generally coincided with the description in the Child Mental Health Specialist training literature of jobs that would be available to them.

Those trainees responding to the question regarding attitude changes they experienced, indicated that they had experienced increased awareness. Most trainees interviewed during the evaluation were apparently dedicated to the profession

of helping children and seemed knowledgeable about the treatment of disturbed children.

The strengths of the program, it seems, are derived from the practical application of knowledge, the instruction by active clinicians, the variety of children and settings, and the resources available at the hospital. Trainees indicated that the program gave them an overview of many disciplines as well as an understanding of the total system for child care. The trainees indicated that they would like more counseling practice and a longer public administration rotation. It was also felt that clinical rotations should be given more credit.

The most positive direct consequences of the program may be stated as follows:

1. Children receive more attention
2. Less exclusive emphasis is placed on custodial care of the child
3. Self-growth and personal understanding of trainees is fostered
4. Participating clinical settings have a better staff-patient ratio because of the participation of the trainees
5. Trainees know what they are doing before finding a job
6. Associate of Arts graduates who were psychiatric technicians find that they have more alternatives, better understanding, and are more treatment oriented
7. Each trainee has a chance to test and verify methods personally

The negative consequences of the training program might be described as stemming from the emotional and financial strains placed on the trainees and the frustration that results when relationships end because of changing rotations. It was suggested that improvements in communication with the affiliated colleges be made or changed, that

more grant money should be obtained, that more alternatives for specialization within each program be provided, and that trainees should be provided with a break during the twenty-four-month program.

Most trainees feel that what changes have been made have been beneficial and that the administration has demonstrated its willingness and desire to remediate dissatisfaction as much and as soon as possible. They feel they now have a voice in program operation. When asked how they conceptualized the role of a Child Mental Health Specialist, most trainees indicated that they saw the role as teacher, therapists, counselor, and parent combined. Master Degree trainees also saw their role as enriching and extending psychiatric technicians' custodial duties. It was indicated that competence is being achieved in essential knowledge and skill areas.

Graduates of the Child Mental Health Specialist Training Program assess their skills and knowledge areas according to the type of job they hold. For instance, Master Degree graduates tend to use special education skills more than Associate of Arts Degree graduates and, consequently, rate themselves higher in those areas. Master Degree graduates indicated a greater use of counseling theories, knowledge of psychopathology, diagnostic testing, crisis intervention, and learning disabilities than did Associate of Arts Degree graduates. The majority of responses on the personal attitudes and characteristics items were positive. At least half the graduates indicated that their attitudes had changed since they began the program, and they attributed these changes to a fair degree to their participation in the program. They rate very highly their overall training as preparation for a successful job. The majority feel that they have had a very good level of success on their job. In contrast to Associate of Arts Degree graduates, Master

Degree trainees report that they had a greater opportunity to utilize their level of knowledge and repertoire skills. All graduates seem to feel that they have good to excellent abilities to work in different settings with a variety of children using alternative approaches. They also feel comfortable operating as a member of a team. The majority of graduates feel satisfied with the current program insofar as it being an ideal training program leading to a degree in child mental health is concerned. Graduates concurred on the strengths of the program. They feel they have been provided with a unique experience of applying knowledge in a clinical setting under supervision, that they could learn what methods were personally effective. They feel that because most courses were taught by active clinicians, their course work had a dynamic quality, and that the breadth of courses was particularly strong.

Weaknesses of the program are related to the articulation of goals and desired program outcomes. Some graduates indicated that they felt there was poor communication between staff, administrators, and trainees, and especially between staff, administrators, and the local colleges. Many feel that trainees should be trained in the use and administration of medication. Most of the graduates indicated that they would change the program in two substantial ways:

1. Provide material in more depth as opposed to broad overviews of many areas
2. Provide alternatives to special education at the Master Degree level

It was felt that the courses most adequately covered included behavior modification, child development, parenting skills, remediation of motor perceptual disabilities, communication disorders, and psychopathology. The least adequately covered courses were

felt to be special education, teaching methods, and counseling methods. It was also felt that administration of medication and practice in conducting group counseling were also inadequately covered. Those Associate of Arts Degree graduates who in addition were licensed psychiatric technicians claimed that their participation in the program has enhanced their effectiveness greatly, helped them to understand and deal with the children more effectively, and provided them with alternative methods in working with the children. The evaluation conclusion was that the majority of trainees have positive attitudes towards the program and that the consensus was that the program was unique and beneficial.

An evaluation of the employers' responses to program graduates showed that the consensus among employers was that program graduates were excellent in terms of clinical competence, job preparation, and overall job performance. Employers tended to rate the graduates' overall job preparation, repertoire of clinical skills, and knowledge of children as being more comprehensive than employees who had not been trained by the program and who were performing the same functions. Most indicated that graduates of the program had a higher level of self-confidence, a greater ability to deal with frustration, a higher level of job performance, a greater ability to communicate with a child on his own level, are better able to evaluate a child's progress and the worth of their own efforts than nonprogram trained personnel performing the same job. The majority of employers indicated that they were extremely satisfied with the work of the graduates and that they would prefer to hire program graduates if positions were available.

There seemed to be a greater differentiation between graduates and their nonprogram trained counterparts when they were employed in a nonclassroom setting. When

functioning in a classroom setting, graduates were only rated as either equivalent to or higher than their nonprogram trained counterparts in the areas discussed above. This, of course, is quite surprising since the nonprogram trained counterparts had an average experience of ten years versus only one year for the graduate Child Mental Health Specialist. In general, therefore, it is clear that the training program, from the standpoint of employers surveyed, has prepared trainees for a successful and satisfactory job performance.

Staff responses to the training program were interesting. The staff from the participating clinical facilities were divided into three groups:

1. Those who, because of being new on the staff, indicated they knew little or nothing about the academic or clinical components of the program
2. Those who indicated that they knew a fair amount
3. Those who indicated that their knowledge of the program was very good

Two patterns of responses were noted in assessing trainee competence. Those who indicated they knew little about the program generally tended to rate the trainees one or two points lower than the staff who thought they were more knowledgeable. The second pattern was that Associate of Arts Degree trainees tended to be rated lowest, and Master Degree trainees tended to be rated highest. The more knowledgeable staff tended to rate Bachelor Degree trainees the same as Master Degree trainees, while staff reporting less program knowledge tended to rate Bachelor Degree trainees similar to Associate of Arts Degree trainees.

All trainees were rated highly with regard to parenting skills, behavior management skills, communication skills, and ability to conduct individual counseling. In

other skill and competence areas, the responses tended to correlate skill with degree level. In the area of probation, juvenile delinquency, and counseling techniques, Associate of Arts Degree trainees were rated only slightly knowledgeable, while Bachelor and Master Degree trainees were rated moderately to highly knowledgeable. All trainees were rated highly on behavior management techniques. Associate of Arts Degree trainees also were rated as only slightly knowledgeable in statistics, research methods, diagnostic testing, teaching styles, and public administration. Master Degree trainees were rated very knowledgeable in all these areas except public administration. There was a wide range of ratings for Bachelor Degree trainees in these areas. Staff rated all trainees higher on research methods than the trainees did themselves, while Associate of Arts Degree trainees generally rated themselves higher than the staff rated them.

The staff rated trainee attitudes and characteristics highest in:

1. self-confidence
2. sensitivity
3. flexibility
4. sincerity
5. cooperativeness
6. patience
7. a good sense of humor

Staff felt that their own work load was extremely heavy. As a result, only half felt that the time available for effective supervision was sufficient. They reported that the most useful feedback devices were informal discussions with trainees.

The staff appears to be satisfied with aspects of the program singled out to build an ideal training program. There was generally a positive response in assessing the programs' success in achieving its goals. The majority of the staff indicated that they would

recommend the continuation of the current training program and that similar programs be established nationwide. Among those staff members who have reservations regarding the program, the consensus was that the programs' goals needed better definition.

As far as the clinical rotations were concerned, the staff felt that trainees tended to participate as active, contributing members of the total treatment team. They rated as very good the overall training as preparation for job performance. The staff felt, however, that trainees were not completely frank on the evaluation forms, although they felt that the usefulness of student feedback and responsiveness of students to the feedback was very good.

A number of suggestions were made by the staff for the elimination of certain courses from the curriculum. Twenty percent of the staff felt that statistics should be eliminated; 28 percent felt that philosophy of education should be eliminated; and 50 percent felt that history of education should be eliminated. Some staff members felt that clinical aspects of the course on the minority child's world should be modified, and that the course on multicultural education should be modified to a workshop rather than a course format.

The evaluation queried the staff's conceptualization of their role in the program and their understanding and knowledge of program goals. Emphasized in goal statements were parenting skills, therapeutic skills, group management, discipline skills, special education skills, counseling techniques, planning, implementation, evaluation skills, assessment skills, comprehension of child development, knowledge of important theories, research techniques, application of knowledge, knowledge of terms, knowledge of available resources, and active participation in all phases of child care. The staff indicated that the strengths of the program include:

1. Practical application of theory under supervision in a variety of clinical settings with a variety of children

2. Eclectic, informal climate

3. Active clinical role of instructors

4. Guest speakers

5. Competencies in academic subject matter (as outlined in Tables 4, 5, and 6)

6. Practical opportunities to develop competencies in administration

7. Clinical seminars to develop:

   - Competencies and clinical skills in:

     - family therapy
     - group therapy
     - sensitivity training
     - psychodrama
     - psychopathology/assessment
     - management
     - treatment

   - Awareness and mastery of the "process" aspects involved in the training program and in the caring of children. These include intrapsychic, transactional, and interpersonal relations. Special attention is devoted to relations with peers, staff, administration, parents, children, and the community.

In fact, this process component is a key factor in the success or failure of such a training program. Unless provisions are made to provide competencies in these areas for the trainees, a child mental health training program will have great difficulty to produce a mature professional with an emotionally stable approach to the wide variety of circumstances in which he or she has to work.

The essential weaknesses of the training program were listed by the staff:

1. Limited funds

2. Overburdened staff

3. Lack of orientation of instructors to the program and its goals

   (This deficiency has since been corrected by providing the instructors with appropriate descriptions of the philosophy, concepts, and goals of the various aspects of the training program.)

4. Repetition of topics

Positive consequences were:

1. Upgrading the background of people working in mental health and supplementing participating clinical facilities with limited care staffs, with motivated, progressive personnel

2. Instilling in hospital workers less of a custodial and more of a treatment orientation

3. More attention to the children

Negative consequences were:

1. Pressure on students

2. Dependency on the hospitals for jobs

3. Lack of goal definition

4. Lack of recognition or use of the Child Mental Health Specialist by clinical facilities and agencies

The lack of ready availability of jobs specifying the employment of Child Mental Health Specialists directly relates to this last point.

Of particular interest is that half of the staff indicated that participation in the training program had influenced their philosophy in practice of child mental health. Many felt that their participation in the program had sharpened their outlook, updated their knowledge of the professional literature, and forced them to examine their philosophies and orientations. Staff seemed to regard a good psychiatric technician just

as important as a good Child Mental Health Specialist. It is their opinion that psychiatric technicians are charged with basic care while the Child Mental Health Specialists are responsible for treatment and individual therapy. Trainees in the program were described to have a more therapeutic effect because they are better able to understand individual dynamics and are motivated to establish relationships. Trainees were described as being more goal oriented and as having a more positive outlook for the children. Under the current system, however, psychiatric technicians are the only ones who are legally responsible for the children. Consequently, trainees can neither be left alone with the children nor can they administer medication. A few of the staff members feel that psychiatric technicians are better able to physically handle children who are "acting out" than are trainees and that they set limits more readily than trainees. Staff are divided in the need for three separate degree programs. Some feel that the Associate of Arts Degree level is appropriate for psychiatric technicians. Others feel that there should be Bachelor Degree and Masters Degree levels only. Those favoring the three degree levels feel that they would provide career mobility, that each program meets different needs (Associate of Arts Degree level--to upgrade cottage staff; the Bachelor Degree level--to lead to graduate work or counseling; and the Master Degree level--for counseling or teaching). The multiple levels were also a value in meeting the needs of a heterogeneous student population.

Staff suggestions for additions to the curriculum include classes in pharmacology, hospital administration, residential treatment, family counseling, psychometrics, and more educational methods courses. Many suggested the use of more workshops. Additional clinical experiences recommended included early intervention and infant

stimulation programs, stronger emphasis on family therapy, and more exposure to intake techniques and placement procedures. Suggested clinical settings include outpatient settings, recreation centers, crisis clinics, and suicide prevention agencies, among others. Most staff members have similar concepts of their roles in the Child Mental Health Specialist Training Program: facilitators and coordinators of clinical experiences. They feel they help students become working parts of a clinical unit, that they serve as resource as well as provide resources, that they provide feedback and a supportive relationship, and that they serve as a role model. The staff generally feel to be motivated and an integral part of the program. They feel that their work would be enhanced if they (1) were provided with or helped to develop a set of operationalized and measurable goals, and (2) if they were more fully oriented to the program.

PORTABILITY OF TRAINING PROGRAM

The four major components of the training program, viz., the administration component, the clinical component, the academic component, and the process component, can easily be generalized to other settings provided that it is possible to include the salient aspects of each. In general, these aspects include:

a. an interdisciplinary approach in order to give the trainee a broad, general training in a variety of fields

b. broadly based applied training to prepare people for working and assuming leadership in a great variety of areas, not necessarily only in such specific areas as working in day care centers or teaching disturbed preschool children

c. additional options for further personal and educational development

The Child Mental Health Specialist should be equipped with skills which enables him or her to deliver mental health services in the early eighties and in the decades to follow. The training approach must be comprehensive and multidimensional. It must include an ecological approach in which the training takes place in real-life settings. Thus, the entire community must be used as a training place. This includes the child's family, the neighborhood, the school, the police station, the probation detention homes, the juvenile court, the church, the recreational facilities, the hospitals, etc. The trainee should learn how to reach young children and adolescents long before they have serious problems. In other words, they should be trained to deal with mental health problems at the source--preventively. This means that the specialist must be able to deal with the total child and his many-faceted needs in his own total environment at different stages of his development.

In order to accomplish this the Child Mental Health Specialist must be able:

1. To teach high school students at a functional level what it means to be a parent with its implied responsibilities. Such teaching should include practicum for the students at nursery schools, kindergartens, Head Start programs, etc., and may involve a "buddy" system with young children.

2. To provide prenatal guidance to expecting mothers as one member of a team of consultants. This team would be composed of a pediatrician, a child psychiatrist/psychologist, a Child Mental Health Specialist, and a nurse. They would hold clinics for psychologically preparing expecting mothers and fathers about the arrival of the child and consult about the attendant feelings and anxieties of the mothers about the birth process and about becoming a parent.

3. To provide emotional support to the parents for the first few weeks after the birth of the infant and to assist them to interact with their child in a meaningful affective manner leading to awareness in the mother of mutuality of experiences between mother and infant.

4. To provide counseling in developmental disability clinics as part of a team to both children and their parents.

5. To provide child care counseling in well-baby clinics.

6. To provide assistance to the staff of child care centers, nursery schools, and kindergartens in the form of workshops, seminars, consultation, etc.

The aim of the training in such early intervention and prevention is to prepare the Child Mental Health Specialist in being able to work in the whole range of situations and circumstances in which one finds children. The Child Mental Health Specialist must be able to provide guidance and counseling at the source before potential problem situations have a chance to develop into serious incapacitating and costly problems. The aim must be for the Child Mental Health Specialist to provide prevention services to the preschool child and for the teacher to take over this function at the school level.

The Child Mental Health Specialist Training Program is aimed at accomplishing the first part. The second part can be accomplished by "mainstreaming" child mental health into teacher training curricula. Once this is accomplished, child mental health will have meaning and then will it become possible to intervene at early stages of problem development.

At the same time, of course, the training of the Child Mental Health Specialist must provide the trainee with the capability of working not only in the area of prevention but also in working with the children across the whole range of disablement, from minimal pathology to the very severely disturbed.

The academic aspects of the Child Mental Health Specialist Training Program, as outlined in Tables 13, 14, and 15, can easily be adopted in total in nearly all academic settings. In view of the fact that a variety of skills needs to be taught, it is important that no course content modifications should be made. This is especially true for the Associate of Arts Degree program. There are obvious advantages of limiting training for basic Child Mental Health Specialist line staff to a two-year period, i.e., an Associate of Arts Degree program. These advantages are both in terms of cost and in terms of the ability to develop quickly urgently needed manpower. There is some question, however, whether this time period is of sufficient duration to provide the trainee with the basic skills necessary for the clinical management of a broad spectrum of children in various settings, whether they can master within this time period enough of the crucial program components--administration, clinical, academic, and process--as well as the ability to act as an effective parent. Only further research will answer this question.

The most difficult aspect of the training program to satisfy is the clinical training. Training locales must not be limited to residential clinical settings. The trainees should learn how to deal with preventative aspects at the source. Thus, the training must take place through a variety of community facilities including an acquaintance with family dynamics, family situations from which the child is referred for treatment, as well as differences in specific neighborhoods, schools, police station, detention homes, probation departments, the juvenile court system, day care centers, nursery schools, elementary schools, and special treatment facilities. The Child Mental Health Specialist must be prepared to look at the disturbed child primarily as a child with normal needs rather than as an appendage to the presented mental illness or delinquency. The specialist should be trained to focus on healthy growth and development. The core of the clinical training must be structured to develop skills in administration, treatment, academics, and process, as well as professional parenting, special education techniques, and clinical management skills. In general, these community resources can be found in any medium-sized community. In addition, however, it is necessary that the trainee has access to both residential and day treatment facilities which deal with the whole range of emotional, social, and behavioral problems of children of various ages. Experience has shown that it is not possible to substitute or eliminate training facilities.

Thus, if the appropriate range of training facilities are not available, a successful training program for Child Mental Health Specialists cannot be provided. Another important prerequisite to a successful program is the availability of experienced clinical personnel who also can provide some of the academic training, or academic personnel who

are also experienced clinicians and who can provide clinical supervision. The use of personnel inexperienced in applied clinical work is inimical to the success of this type of training program.

SUMMARY

The findings of the present project can be summarized as follows:

1. Notwithstanding the complete lack of training of child care personnel throughout the United States, especially at the line level, no standardized training programs are as yet in existence.

2. A uniform training program designed to meet existing needs must be developed at a national level.

3. The training of child care personnel must fit in with existing patterns of education and career-ladder opportunities.

4. Training programs in child care must be at different levels of training in order to provide child care personnel with different levels of skills and competencies--the appropriate levels being the Associate of Arts Degree level, the Baccalaureate Degree level, and the Master Degree level.

5. The applied part of the trair ing must be real-life situation oriented dealing with the total child in his usual environment, as well as oriented to the child in a variety of treatment environments, and must be integrated and complemented with academic training aspects. The applied experiences should consist of at least twenty hours per week.

6. Academic courses should be taught by academic personnel who also have applied

treatment responsibilities or be taught by personnel working in applied areas who would be eligible for a joint clinical appointment with the academic institution providing the academic training.

7. Course content must be relevant and should include the content especially established in the present project as listed in Tables 4, 5, and 6, on pages 68-70.

8. Clinical supervision must be provided by experienced rather than by recently graduated clinical personnel.

9. Clinical experiences must include the situations as described in Tables 7, 8, and 9, on pages 76-89.

CONCLUSIONS

1. It is feasible to design a uniform training program which will train child care personnel capable of taking positions in a wide variety of situations dealing both with normal, disturbed, and delinquent children.

2. Training programs for different levels of Child Mental Health Specialists can be portable provided that the prerequisites regarding the inclusion of specific academic content material (Tables 13, 14, and 15, pages 135-148) and sufficient applied clinical experiences can be provided (see Tables 7, 8, and 9, pages 76-89).

3. Although the need for trained personnel has been acknowledged and recognized for some time by those working in the field, no coherent, comprehensive, and standardized training programs, as yet, have been developed. Since natural evolution does not fill this hiatus within acceptable time limits, it is clear that responsible people in decision-making positions need to take the leadership in seeing that a uniform Child Mental Health Specialist training program is implemented on a national basis within the shortest possible time.

4. We can no longer afford to wait for the training of child care personnel to proceed either by chance or in a piecemeal, haphazard manner. A special project needs to be undertaken to develop at least thirty different training centers throughout the country.

CHILD CARING

THE FUTURE

IMPLICATION OF FINDINGS

There is a unanimous agreement among people working with mentally disabled and delinquent children that the treatment of such children has suffered from the lack of specifically trained child care personnel. Today we know that the care and treatment of children cannot be done adequately by anyone who has had the training only in the care and treatment of adults. Today we also know that even specialists in children such as child psychiatrists and child psychologists need at least two years of actual structured working experience with children before they can provide adequate care and treatment. What is needed then are:

1. Specially trained child care personnel and
2. A variety of child care personnel with two years of applied internship experience respectively before graduation

In a previous section of this report, a brief summary was provided of the numbers of children who suffer from emotional, social, and behavioral disorders of a serious enough nature to warrant professional attention. Even a most conservative conclusion indicates that literally thousands of Child Mental Health Specialists are needed to effectively care for and treat these children. We can no longer afford to hope that these disorders or problems magically disappear when the child becomes an adult.

The implications of the findings of this project clearly show that it is possible to train people to become effective child care workers who are capable of

functioning both as part of a team of personnel working in this area and as a professional in their own right. They also show that we no longer can afford to limit our efforts in the child mental health field to repairing psychological injuries sustained by children over a period of years. It is time that we address ourselves to aspects of preventing such injuries from occurring whenever possible and with whatever means now available to us. This can be accomplished by "mainstreaming child mental health" as an integral part of compulsory education.

Mainstreaming Child Mental Health

Throughout history socioeconomic forces have been the major determinant in establishing the patterns of child rearing and child care. At whatever historical era of man's development we look, we recognize that he has struggled with himself and his environment to survive physically and psychologically. At each state of his development, he learned to deal with the human condition with the help of insight and the cultural tools that were available to him. The Judeo-Christian civilization tried to deal with the human condition by espousing moral principles grounded in a theological concept of the universe. The Old Testament reveals some basic mental health principles, as we conceive them at the present time, clothed in moral and theological exhortations. The evolution of the Christian civilization from the Judean style of living has largely contributed to the principles of morality to embrace large segments of humanity. This, over the centuries, was accomplished only through both

small- and large-scale destruction and negation of some other moral principles or theologies involved. The history of the spread of Christianity, often by conquest, is well known.

In our contemporary society we see a somewhat similar struggle for man's physical and psychological survival.* These are viewed not in terms of theological and religious concepts, but in terms of philosophical, ethical, scientific, and political approaches to life, i.e., the democratic process of resolving the problems resulting from the human condition on the one hand, and the Spartan, authoritarian, militaristic approach to dealing with man's political needs on the other hand. The Athenian culture approached basic principles of mental health both politically and educationally, as expressed in the principle mens sana in corpore sano. Both these ways of dealing with the human condition have been incorporated in Western civilization by espousing political democracy and enlightened educational principles. Both these principles have led to unprecedented political, scientific, and economic progress in Western civilization over the past three centuries or so.

Unfortunately, the political and economic progress in Western civilization has also brought in its wake new, massive problems. The largest of these are the purely human values which were inherited from the Judeo-Christian civilization in form of moral principles. In addition, the Greek civilization--in the form of mens sana in corpore sano--has not kept pace with our scientific and technological progress. We

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*The term "psychological survival" includes the Biblical concept that man does not live by bread alone. It includes man's need for personal, social, moral, and ethical self-fulfillment, and also includes the pursuit of happiness in its broadest meaning.

have failed to counterbalance the technological progress with the progress of human values. We have failed to translate the theological principles into psychological terms of enlightened self-interest with which we could reach large segments of populations. Obviously, we cannot revive and universalize theological terms in their original form which may have served their purposes during certain stages of civilized man's development. We cannot use them as precepts for living under conditions in man's current developmental stage of civilization. We need to look for basic principles which could lead to the improvement of the quality of life of each individual and which could not be used for the exploitation of inhuman purposes. Such basic principles could develop into guidelines for enlightened self-interest leading to psychological survival of individuals as well as society.

In looking for such an approach, it is reasonable and logical to ask ourselves what forces contributed to the enormous technological progress in our society in the past one hundred years or so. The answer to this may be that it was compulsory education. In the Middle Ages, for instance, the mastering of the three R's was limited to a very small minority of the population, to the nobility and the theocracy, in this case to the Catholic Church and the monks in the monastery. The Renaissance is a good example of the burst of human creativity. Scientific curiosity, exploration of the environment, and the encouragement of the pursuit of education and mastering of the arts was made possible by a climate which encouraged or made possible the individual's psychological development.

When we examine our educational system with an open mind and with the awareness of what psychodynamic forces can do to blind us when dealing with emotional

components in our system, it is not surprising to find that the emphasis has been almost solely towards the intellectual development of the child. The development of the full psychological potential to run parallel with his intellectual development has largely been ignored. In fact, we have conveniently overlooked that the education of a child towards becoming a full human being involves an integration of all the child's developmental forces, the affective as well as the cognitive ones, which could lead to a fully integrated, well-functioning, mature adult. The widespread human mastery of the nonhuman environment in our most advanced Western civilization testifies to the effectiveness of emphasizing intellectual development. Unfortunately, it has completely overlooked the affective component towards counterbalancing this one-sidedness. Such oversight may, perhaps, have deeper roots in the evolutionary adaptability of man.

Whatever the causes for the one-sided development of man may have been, whatever the historical forces may have been, they have made him blind to the needs of developing his full psychological potentials, his mastery of emotional forces along with the intellectual competencies. We no longer can afford to ignore this deficit. This problem of giving equal priority to the EMOTIONAL development of the child as we have given to his INTELLECTUAL development is a problem of a magnitude which will take a great deal of time and will require the best brains that can be marshaled in this country of educators, clinicians, sociologists, anthropologists, and biological scientists.

Corpore Sano in Mens Sana

We now know that the Greek maxim that a healthy mind needs a healthy body is a circular and reciprocal process. It is not a one-way street. There is a mutuality

between the body and the psychological forces in man. We have, in recent years, recognized that the transactional process between mother and child, or between one human being and another, under favorable conditions, involves a certain degree of mutuality of experience- a process by which both people involved are affected. We certainly know that the same applies to the body-mind dichotomy. This insight, however, has not been applied to the education of children. On the surface of it, we can rationalize that we have no understanding of how to include an affective component in the education of the child in the school system and how to promote the emotional integration with the intellectual education and social development of the child. More probably it is because of psychodynamic forces that inhibit us to look at the problem with the scientifically magnified psychological microscope. While we still do not have the exact tools of preventing such serious mental illnesses as childhood schizophrenia, autism, and other mental afflictions, we know much more about the psychological development of infants and children than we are willing to apply, both for psychological and economic reasons, to bring out the full potential in every child who attends any school system. We have made rapid scientific and technological progress but have not yet addressed ourselves to the development of the full psychological and creative potential of every child in our society. Such an approach is most effectively done by those who are responsible for the education of our children: the TEACHERS. Making the affective, psychological component part of the public education of the child does not mean to impart to children knowledge about mental health. What is meant is to involve them in the process of healthy living early in life through their emotional and intellectual experiences in the school setting. Thus, they will learn

what mental health is about and how it will affect their lives through the transactional process in the interrelations with others in school. Montessori has early recognized that even very young children can learn complex intellectual problems if the proper means are adapted to develop such skills in accordance with the child's developmental age. Similar principles and methods could be devised and applied to involve very young children in a style of life which incorporates sound mental health principles. We have known for some time that it is not enough to know intellectually what mental health means. In addition to the intellectual understanding, one has to experience this emotionally on a gut level in the process of living. New insights and understanding have to be developed to apply such knowledge to gut experiences in the classroom, to apply such an understanding to the relationship between teacher and student, between student and student, between teacher and parent, between student and parent, between teacher and administrator, and between the classroom and its members to the community and to the political forces of society. This process could be applied by training people in group therapy, sensitivity training, role playing and psychodrama, et cetera. The best way, however, to teach children and to make them aware of the process of living in a small community outside of the home, such as is available in a public school, is for the teacher to be trained through the process of becoming a teacher. This process cannot be achieved by book or lecture since no book or lecture can convey this awareness. One has to experience the process and become aware of it during the supervisory hour or in seminars which also include discussions with staff, peers, and teachers. Experience shows that a clinical setting for the care and treatment of children is probably the best place for getting involved in such a process, provided conditions are created

that the awareness of this process is made into a focal point of training. This process component in the training is of crucial importance for the development of the teacher of the future and could be made into a daily living experience for the school children at their own level of understanding in the classroom.

In the training of teachers, child care personnel, and other mental health personnel, we seldom, if ever, single out the training process that goes on in a clinical setting for special attention and scrutiny. It is unfortunate that the awareness of the process which everyone has to go through in a clinical treatment setting for children has been treated in such a cavalier fashion. Little has been written about it in the literature except when dealing with the supervision of therapists in training by their supervisors. The process which a teacher trainee experiences in a clinical setting for the treatment of disturbed children, if made fully aware to him and the focus of discussion, could be turned into the single most important experience for his future professional activity for integrating child mental health and child education.

From the very first day of his training, a teacher trainee should be thrust as an active participant into complex settings involving both normal and disturbed children. A multitude of transactional events takes place between trainee and children, especially severely disturbed children, staff, supervisor and administrator, and other trainees. The trainee has to deal with many children and staff, each one with various skills and competencies, representing a number of disciplines which include child psychiatrists, psychologists, social service workers, teachers, nurses, psychiatric technicians, housekeepers, and lay administrators. Each functions on different levels of competencies from the highly sophisticated and well-trained clinician to the least

sophisticated in the area of background experience. To deal competently with such a situation requires the development of an extraordinary amount of insight, coping ability, and understanding of the process which takes place. If one also includes the personality differences of the children, staff, and trainees, and the personal psychopathology which we inevitably bring along with our own competencies, one can appreciate the complexity of such a situation. It is this process component of the future teacher which, if properly taken advantage of in seminars and discussions, is probably the most important growth component towards being able to integrate child mental health and education.

A teacher who has gone through a training process over a four-year period, which also includes the contents curriculum which focuses on child development, special education, life sciences, social sciences, and communication disorders, will be well prepared to make use of the process component and the affective component in the education of normal children in the classroom.

When Adolf Meyer introduced the concept of mental hygiene in the first decade of the century and used in his teaching the concept of commonsense psychiatry, he implied that knowledge about the human development and psychodynamics of abnormal development should be common knowledge to everyone, and that this knowledge and its application should be widespread. It should be, as we would say today, a household concept. How to live creative, mentally healthy lives should be the right of each individual child and adult. In fact, the proposal to train teachers in the child mental health field to better prepare them to help children integrate intellectual components, affective components, and living processes early in life so that it becomes a

pattern of living and a standard for society is an extension of Adolf Meyer's concept of mental hygiene and commonsense psychiatry. Such education, if made into a universal experience in our society, will prepare future adults to guide their lives by considerations of enlightened self-interest rather than be guided by external controls. Such an education will prepare adults towards full, rich, autonomous living without interfering with the welfare of others and enable society to survive in a complex and small world.

The academic curriculum for the future teacher, therefore, should include subjects in the biological, social, and anthropological as well as the clinical, psychological, educational, and communication sciences. The literature and textbooks dealing with those subjects are well known and routinely used in colleges and universities. The student who is preparing himself for a career in work with children, however, needs also to acquaint himself with the writings of Erikson, Bowlby, Winnicott, Spitz, Piaget, and Gesell. Psychodynamic child development, as reflected in the writings of these authors, is especially mentioned here because familiarity with these writings is crucial for the understanding both of the normal and exceptional child and is not widely taught in academic settings.

To develop competencies in the child mental health field, it is also necessary to rotate through clinical and nonclinical services dealing with normal and vulnerable infants--infant stimulation and developmental disabilities programs, through a therapeutic nursery setting dealing with emotionally disadvantaged and vulnerable preschool children, through residential or day treatment settings for disturbed children in the middle years and for children in the early middle and late adolescent years, through a

pediatric hospital for normal children and adolescents with acute and chronic medical and surgical problems to develop skills in psychological care for hospitalized children requiring medical or surgical treatment over a period of days, weeks, or months, through delinquent adolescent clinical or correctional facilities, through continuing care services in county mental health centers, and through special education classes or in community learning centers. Thus, over the total time it takes to train teachers, the student will have just enough time to master the academic and clinical components of the training curriculum in its basic dimensions.

It takes about five years to develop a teacher for a pub school from the time of graduation from high school to the completion of the Masters Degree in Education. Compare this with the possibility of producing, over a two- to five-year period, Child Mental Health Specialists capable of dealing with infants at risk with developmental disabilities, with children who need education in a therapeutic nursery setting, and with disturbed children in various clinical settings. It would not be difficult to recognize the potential for the teacher of the future if he or she would have five to six years of training incorporating child mental health skills and experiences.

Such versatile, interdisciplinary professionals, child-oriented in their outlook and child-centered in their activities and advocacy, trained in large numbers over the next twenty-five years to replace the present fragmentation and piecemeal approach to children--average or exceptional--could have a significant impact on children in all areas: development, prevention, education, behavior, and rehabilitation, and in close collaboration with the work of child psychiatrists, child psychologists, and child neurologists. Even though the new professional may, in time, replace the present

multiplicity of various professionals--traditional teachers, psychologists, psychiatric social service workers--in work with children, it is reasonable to assume that the demand for these services will continue or increase as more attention will be given to the need for mental health maintenance and prevention of mental disabilities in the population at large.

The cost to the taxpayer of developing such a new professional need not be much more than developing a traditional teacher; but the return in terms of effective services to the children of the new profession, awareness for the need of preventive measures in the child mental health field, the need to promote positive mental health in children in the homes, neighborhoods, schools, and community settings, could be very significant in terms of improving standards of mental health in our society.

A broadly conceived interdisciplinary new professional in the child mental health field can convincingly emerge. It is reasonable to assume that this new versatile, multifaceted professional teacher may, in years to come, have a significant impact on the education of "normal" children, on the prevention of emotional, mental, and social disabilities in children, and on their rehabilitation. A teacher who had spent between two thousand and three thousand hours of clinical work with a broad spectrum of disturbed children under expert supervision will, if properly trained, forever be aware of the need to foster positive mental health in children in their ecological home environment, in public and private schools, on playgrounds, and wherever he/she is called upon to deal with children. The new interdisciplinary professional will have a more comprehensive grasp of the child's problems based on his familiarity with the multifactorial contributions to the shaping of the child's personality: the genetic-biological,

the developmental-psychological, the environmental, and the child as a member of a family unit and as a member of the larger society.

Because of his or her basic training in psychodynamics of child development and child psychopathology, the future teacher will not look at the child as a small adult who is expected to think, feel, and behave in adultomorphic ways. Such a teacher will carry away from the training the need to understand the child as a growing human being who is continually and flexibly adapting his learning and coping skills in line with his own individual maturing process. He will not be pressed into a process of adult-type thinking and behaving until he has reached the stage of maturing which will enable him or her to understand the adult environment. In the role of a teacher the child mental health professional will bring a new dimension to the classroom: the awareness of his or her role in the process of teaching and in the process of learning on the part of the children; the awareness that this is a process of mutual growth on the part of the child as well as, and particularly, on the part of the teacher. This awareness will have developed and sharpened during the clinical training period of the future teacher.

In proposing the use of such future teachers for normal children in public schools, it is not meant to use such a broadly trained child-care professional in a clinical sense but in the process of education sense. It is not meant to blur the boundaries between healing and teaching, to confuse the roles between the teacher and the clinician. The role of the future teacher needs to be clearly delineated from the role of the child mental health clinician. What is proposed is the introduction of the process aspect of child mental health in the classroom teaching rather than the

clinical aspects of treating. It is the process of awareness of the mutuality of experience between teacher and child, child and child, teacher and child's parents, teacher and administrator, and other staff hierarchies in the school system.

Another aspect that comes to mind is René Spitz' concept of fundamental education. Fundamental education, according to Spitz, is the process which produces change in the child through affective interchange between mother and child. The term learning, on the other hand, is reserved for input and storage of information (62). Still another process aspect that comes to mind is the democratic way of decision making in the classroom. Other affective components of the process could come into play in the education of the normal child in the classroom leading towards a higher degree of integration of the various developmental lines and various aspects of the child's functioning--educationally, socially, and emotionally--towards greater adult maturity and autonomous thinking which our democratic society will require of its future citizens.

The way to understanding health has been through the study of sickness, the road to understanding normality through the study of pathology. The road to understanding normal learning could be shortened through the study of learning disorders. This has been the tradition in training young students for medical careers in medical schools. This also has been the road to travel by psychotherapists. Why not use it for teachers to learn how to deal with psychopathology in children before taking on the responsibility to develop vigorous mental health in normal children in a classroom in public schools?

One may expect that the postindustrial era will present new challenges to the upbringing and education of our children and to the child mental health field. Some

of the challenges in this regard are beginning to emerge in the technologically advanced societies. It has been observed that the development of children is affected not only by the immediate environment, the families, parents, and siblings in their own homes, the neighborhoods, and schools which they attend, but also by events in the distant environment and the politics of their communities and those in other parts of the country and the world.

Urie Bronfenbrenner (63) refers to the child's enduring environment as consisting of two concentric layers, one superimposed on the other. The inner layer is the most visible one in the child's most immediate environment. The supporting and surrounding layer in which the immediate setting is embedded limits and shapes what occurs in the immediate surroundings. Bronfenbrenner (64) addresses himself to the child's ecological environment as a social scientist and points out how important it is for the public policies to consider both environments when dealing with children. He refers to public housing projects, health insurance and health delivery systems, homemaker services, and to any other social system that may affect the child's well-being and his development. Sibylle Escalona (65) in a recent essay, "Children in a Warring World," deals as a clinician with the psychological impact on the child's development which social and political events in this and other parts of the world can and do have on the psychological development of children. She states that children, especially children in middle childhood years, assemble images, meanings, and interpretation of themselves and their place in the social structure of what they come to know about social institutions--the courts, police, military, government, money, etc. In this perspective, the Indochina war, the recent war in Lebanon, famine in

Africa and in India, hijacking and the taking of hostages, all have an impact on children who are remote from these events but old enough to watch television and to listen to conversations of their elders. She states: "Most children have a world picture that is more than an extension of their own experience, although filtered and at times distorted through the very personal themes to which these features of the environment are relevant: power, conflict, fear, security, status, anger, hatred, etc., ... It is the discrepancy between what youngsters are expected to develop inwardly, as primary mechanisms of control and guiding value structures, that constitute a serious hazard to ego development." Further: "In technologically advanced societies, the more the real world contains violence and the display and exercise of crude power, the more difficult it is for children to come to terms with rage and hostility as necessary and inevitable components of their personal inner lives." She compares the impact of these events on our middle-class children with the inner chaos, fragmentation, rage, jealousy, and lack of effective integration often found among ghetto children. "The greater the discrepancy between values and beliefs upon which child-rearing practices are based and the actual events and behaviors that take place in the social environment, the more difficult it is for children to achieve reasonable integration of ego functions and a sense of acceptable identity. The more a society fails to constrain internal contradictions and the less intact and stable it is, the greater its failure to provide the necessary nutriments for individual development." Escalona maintains that children living in such a technologically advanced society suffer from a deprivation syndrome in their personality structure. Children living in such a society are deprived of sufficient nutriments for developing ego strength and internal regulations or structures that spell

maturity. She makes the point that there is an inextricable link between development of internal regulations, integrated ego functioning, and societal disruptions. Such a link may affect such aspects of functions and development as learning, delay capacity, self-esteem, an ego that is active yet flexible in relation to impulses from within and to external reality. The deprivation syndrome that children experience living in a society that does not practice what it teaches, in which social reality diverges thoroughly from the values that they are teaching, may lead to a variety of deficiencies in the makeup of the child and may explain the reluctance of even well-taught children to learn to read and write, and the preference of college students for drama, film, and dance to conventional liberal arts studies, and may lead to vulnerability to drugs, alcohol, mysticism, and magic among children and young people. The need for change in our historical development towards a higher level of societal functioning which in the past has been a generational task in which our youth has played a major role is now considered as being in jeopardy. The very personality characteristics that are required in order to have a share in changing our environment remained undeveloped precisely because social organization is so much in need of change.

The new future professional teacher, in his/her role of a teacher of normal children, can be trained to understand the psychodynamics of child development and the challenges that advanced technological societies will make on its school teachers. Such broadly trained teachers, during their training period, will have learned how to deal with children who were facing potentially traumatic events in their own families, threats of violence, and separation from parents for a number of reasons, or who were facing hospitalization and medical or surgical intervention, and

were able, through appropriate intervention, to prevent short- or long-term consequences of their experiences. A teacher sophisticated in the child mental health field could use similar process intervention to avoid long-term consequences to their personality structure as a result of social and political forces that may deeply affect the child's development. Such effective intervention could be the result of collaborating efforts between teachers and child mental health professionals such as child psychiatrists, child psychologists, social scientists, and anthropologists. Those of us who have had experiences as school consultants are aware of the communication gap that at times exists between the child mental health professional who had no training in education of children and the educator who had no training or any knowledge in the child mental health field. The new professional trained in the child mental health field will be in a better position to collaborate with other professionals in this field, and this may help develop new approaches to deal with psychological deficiencies in children resulting from disrupting forces in our technological society. The training of the future professional teacher in his/her role as a teacher of normal children is only one aspect of a massive and comprehensive effort that needs to be made and directed towards preventing mental and social disabilities--long before those disturbances have hardened into semipermanent or permanent personality distortions or periodic malfunctioning.

Such an effort, to be successful, needs to be all encompassing, at least on a scale comparable to the all-out efforts which were made years ago to eradicate preventable childhood diseases--on a scale comparable to prevention which was made in regard to preventive malnutrition and various nutritional deficiencies in children

and adults--and, finally, on a scale comparable to the introduction of compulsory elementary education. Such efforts could include preparing children, beginning at junior high, to become future parents through courses in functional child development and family dynamics, principles of mental health, et cetera.

Summary of Implications of Findings

The implications of the Child Mental Health Specialist Training Project's experiences are:

1. The need to train Child Mental Health Specialists on a national scale.

2. The need to include child mental health training into teacher training programs throughout the country.

3. The need to disseminate child mental health and child care knowledge to people working with children.

RECOMMENDATIONS

As a result of the implications of the findings of the Training Project, it is proposed that:

1. A skeleton staff be maintained to provide the necessary Project continuation until a formal decision can be made regarding the following dissemination proposals. Until a decision has been made regarding these proposals, the skeleton staff would consist of the current project director, secretary, half-time research assistant, and consultants.

2. Both academic and clinical materials be prepared for the three levels of Child Mental Health Specialist training. The materials would follow the outline as in the three final prototype programs (Appendix I). The materials would be researched to insure continuation, progression, nonoverlap, and integration and congruity of academic and applied aspects.

3. Thirty Child Mental Health Specialist training programs be developed at thirty different locations throughout the United States. This process would involve the selection of appropriate academic institutions near child care facilities in major population areas. Steps developed in the marketing procedure then will be followed to attempt to "market" the program to both the respective academic institutions and clinical facilities.

4. Curricula be examined of fifty major teacher training institutions throughout the United States for the preparation of specific child mental health training materials

and representation be made to the respective academic authorities for their inclusion of these materials into their academic teacher training programs. Basically, this proposal would peruse an existing teacher training program to determine how child mental health material from the prototype programs (Appendix I) can be integrated into this program. Specific materials will then be prepared for possible adoption, and steps will be taken to attempt to "market" this material to the institution.

5. Relevant treatment, child care practices, and child mental health information be obtained from the professional literature and facilities of a variety of countries for preparation and dissemination to people working with children.

DISSEMINATION

Dissemination alone is no guarantee that information will be adopted. Experiences by a number of people who have disseminated information from very successful projects relating to treatment or money-saving options to appropriate sources have invariably shown this to be the case. Representations, explanations, and discussions about new material must be made; and specific steps need to be undertaken to initiate implementation if it is desired that a particular program will be accepted. As a result, dissemination of information in the denotative sense only is not sufficient if it is desired that a certain program be adopted and implemented.

Implementation must be preceded by a concise but explicit documentation of the need and purpose of the respective training programs at the three degree levels. This includes the documentation of the various academic courses including the course content, specific teaching aids and evaluation materials, the various applied experiences needed, and the skills to be acquired. Documentation would also include the preparation of instructor, supervisor, general clinical agency staff, and student manuals.

The second step in the total dissemination process would consist of selecting thirty potential training sites. These would be located in or near large population areas with access to the required clinical and community child care facilities necessary for the appropriate applied training experiences. A specific plan for marketing the training program to both the academic institution and the various community agencies and facilities must be developed in a step-by-step fashion. This preparation for

acceptance will be based on the experiences of implementation of the three training programs in the present project and will be modified as more experiences for the implementation elsewhere are amassed. It is estimated that this phase will take anywhere from three to four years after the first step of the three-step dissemination program has been completed.

The third step in the total dissemination process would consist of examining the curricula of the major teacher training institutions in the United States to determine the most appropriate manner in which relevant child mental health materials might be included into the prospective curricula. Specific materials adapted to each institution would be prepared, and appropriate representations would be made to the various institutions for the possible inclusion of this child mental health material into their teacher training program. It is thought that this phase would take approximately four years. Thus, the total dissemination time would take a minimum of four years and possibly six years and could result in the creation of thirty training programs throughout the country and the inclusion of child mental health training into fifty teacher training institutions.

The time frame for proposal 2 would be approximately twenty-four months. Proposals 3 and 4 would take thirty-six to forty-eight months and, if approved, could start after the second proposal has been completed. Proposal 5 is not time bound and can be accomplished concurrently with any of the other proposals.

EPILOGUE -- PROLOGUE

EPILOGUE - PROLOGUE

We have a tendency to oversimplify internal psychological events. Our psyche seemingly has a need to maintain an orderly internal environment when confronted with new events, sometimes even at considerable discomfort to its intellectual processes. We create little psychological hooks to hang on them our psychic hats. We create slots and compartments to categorize, to typify, and stereotype complex human and sociological events.

This is also happening to the concept of the Child Mental Health Specialist. I have heard and seen it categorized as a "type of educateur mouel," as a clinical model, and as a medical model. Some colleagues have asked why I did not call it the educateur model, as the French and French-Canadian have done. In discussions with fellow mental health professionals, surprise was expressed that the breadth, depth, and scope of the Child Mental Health Specialist concept did not come through in my previous writings as they understood it from discussing with me the concept of the new professional with the new, versatile roles and functions. Even the evaluation of the training program criticized a lack of understanding of the roles and functions of the new child care professional by some staff members and students as being one of the deficiencies of the training program. It is, therefore, quite proper at the conclusion of this report to try to explain in broad outlines how and where the concept of the new child care professional was conceived and developed over a period of many years.

It was conceived in a state mental hospital setting at a time when it had about seven thousand adult patients, including about one hundred twenty children and young

adolescents, in custodial care, as was routine for state mental hospitals a quarter of a century ago. The cost of custodial care to the taxpayer was then about five to six dollars per day per patient. Under the circumstances existing then, it was understandable, however intolerable, that no distinction was made between the housing, feeding, clothing, care and treatment of ten-year-old boys and girls and forty- and fifty-year-old adults. To a physician with many years of medical training and practice, such conditions were difficult to reconcile with his medical and personal ethics. To give up and to run away from a difficult situation was unacceptable to the background of his upbringing. There was no alternative but to endure professionally, to survive psychologically, and to do one's best to improve conditions for the care and treatment of these children.

A formal proposal to create a new child-caring professional for the hospital was submitted to the medical director in 1955, and periodically thereafter, without success. Twenty years after it had been conceived, I was invited to testify at an Assembly Select Committee on Mentally Ill and Handicapped Children of the California Legislature. Following this session, in the Spring of 1970, I was given the green light to proceed with the formal training program for a new kind of child care professional. My experiences of dealing with severely disturbed children as medical program director during the previous two decades have broadened my view of the many-faceted needs of these children. As a clinician-administrator, I became aware of the tremendous impact which the immediate human and physical environment had on these children. I became aware of the impact, for better or for worse, which the top administrative echelon of the hospital at large and the Department had on the care and treatment of these children,

the various county facilities, the public media, the political situation, the Legislature, and society at large.

The lesson learned from my experiences as medical program director have become part of the developing concept of the skills and competencies of the various roles and functions which a child care professional should develop. An improvised training program for staff was introduced in the early fifties and conducted over a period of years. Many innovative treatment modalities were introduced to improve standards of care and treatment. Emphasis was placed on education, and particularly on special education, for the children in the early fifties. Regular, often daily, visits to the nearby communities, and particularly the community nursery schools, were inaugurated and continued over many years. A speech and language department was established--the first one in any state hospital--with the help of private funds collected by the parents and friends of the hospitalized children. Satellite Treatment Homes were conceived and implemented for individualized care and treatment of severely psychotic children, first on the hospital grounds and later on in the nearby community. This was done in an effort to replicate family living conditions to normalize the children's lives in their natural habitat while being cared for and treated over a period of years.

When the time came, in the Spring of 1970, to implement the training program for the new child care professional, the many experiences: administrative, clinical, and educational, to meet the treatment needs of the children, could be incorporated into the concept and training of the new child care professional. Preventive aspects loomed large in my mind, in part because of my medical background, but mostly because of the experience of treating children who came to the hospital so emotionally,

mentally, and socially crippled that it had taken many years to bring minimal changes about in their condition, at an increasingly enormous cost to the families and to the taxpayers, and at the cost of wasted lives to the children, to their families, and to society at large. To make preventive intervention mandatory for every infant with biological deficiencies at birth, for whatever cause or reason, was a logical conclusion. To make primary prevention for all children born biologically intact and healthy at birth a requirement at all stages of their development, during infancy, during preschool years and school years, and adolescence, seemed to be common sense for any society which has regard for the well-being of its citizens. By primary prevention is meant the right of every child to have an opportunity to develop its full psychological potential for vigorous mental health as a child and as an adult.

All these experiences and insights were ready to be built into the concept of the new child-caring professional. None of the child care models which I had studied in the early fifties in various European countries, including England, Scotland, France, Switzerland, Holland, Denmark, Sweden, and Norway, could be exported to and meet the many and different needs of our vast, diverse, kaleidoscopic, complex, industrially and technologically sophisticated, sociologically and politically dynamic, and experimentally minded society.

The concept of a new, homegrown model of a child-caring professional needed to take into consideration the dynamism and complexity of our society in which our children will grow and develop in the coming decades. From accumulated clinical research and experience during the last three or four decades, a rich reservoir of knowledge of how children grow and develop has been stored away in many libraries and waited

its application in the daily life of children and their families. The concept of the Child Mental Health Specialist envisioned that this knowledge can be effectively taught to large numbers of motivated and suitable students who could apply it to children in many different situations, many different levels, and to children of many different backgrounds, rich and poor, black and white, with high IQ and low IQ, biologically healthy or organically deficient, to families, to children in neighborhoods, to children in institutions, in hospitals, in private and public schools, in a preventive way.

Prevention can be practiced in many different ways, in different situations and on different levels, and at many different age levels and along different lines, on a broad social level, on a community and school level, on family and neighborhood levels, before a child is born, after its birth, and at different developmental stages, on a psychological, social, emotional, educational, and clinical level. On whatever level prevention is practiced, it involves people, at least two people: the child and a caring adult, a parent, a sibling, a member of an intergenerational family group, a teacher, a mental health professional, a member of a peer group, and a law enforcement officer. And whenever and wherever people are involved, process is always involved; and process needs to be made the main tool of the child-caring professional for prevention as well as for intervention. If one is process conscious and process oriented, there is no need to think in terms of goodness or badness of the child, or of people in general in terms of being amoral or asocial. When one is process oriented when dealing with children, one learns to think of mutuality of experience--of a two-way street of give-and-take, of teaching and being taught, of treating and being treated, of helping the child grow

and of growing professionally and personally. Trained in such a way, a child mental health professional will learn to deal with many different children--delinquent, psychotic, borderline, organically damaged, or learning handicapped--over a period of many years without developing the proverbial "burned-out" feeling.

Process awareness and process orientation is, therefore, of critical importance in the training of the new child care professional and could play a major role in primary prevention if applied knowingly, explicitly, and deliberately, in the classroom, in public schools, in private schools, on playgrounds, and whenever and wherever one deals with children. In a process-oriented classroom learning how to care for another person, for peers, for teachers, for students, for family members, and for people inside and outside of the classroom will be at least of equal importance with information gathering and knowledge acquiring. Such a process attitude would soon find application outside the classroom in a practicum such as would be available in day care centers, Head Start, clinical settings, Satellite Treatment Homes, et cetera. Together with courses in functional child development and family dynamics, the school experience would lead to strengthening of family life over a period of time, thus creating a liaison between school and family and reinforcing their roles in providing opportunities for children to grow and mature towards becoming mentally healthy adults. Such an enterprise would require the training of large numbers of Child Mental Health Specialists and re-training large numbers of nonprocess-oriented teachers.

It seems that societies have life cycles of their own similar to the life cycle which individuals, families, and various social groups have in the course of their existence. Periodic changes are the essence of the life cycle, often accompanied by

critical transition periods, to prepare and strengthen the organism for more mature and effective coping abilities with new challenges--in the service of evolutionary adaptedness--for the need to function. This seems to also apply to societies. If one is to judge from the events of the past two decades or so, our society seems to enter a new cycle in its historical destiny; and a reordering of the hierarchy of its priorities may well determine the kind of society we will become in decades to come.

In an agrarian society such as existed in the Middle Ages, education, literacy, the teaching of the three R's were limited to a very small segment of the population and were the prerogatives of the aristocracy, the nobility, and the clergy. Later on, when the feudal society expanded to include a mercantile orientation, it added another segment of its population to master the three R's and to benefit from the privileges resulting from the educational system. With the advent of the industrial era, society needed large numbers of educated people for the Industrial Age to develop and to prosper; and compulsory education was introduced. With the introduction of compulsory education, the mastery of the three R's, education and literacy has become almost universal and ubiquitous. In less than half a century our society has made enormous and spectacular advances in technology and, with its help, in the mastery of its environment. Theoretical knowledge it acquired in physics, chemistry, medicine, surgery, and nutrition, it promptly applied to improve living conditions of large segments of its population. It put it to greater productivity in agriculture and greater productivity and inventiveness towards increasing man's longevity and physical well-being. Through application of its theoretical knowledge, and with the help of its existing technology, knowledge in medical sciences and surgery have made exciting

and spectacular gains. Findings in the science of nutrition were applied and translated into healthier food to increase the physical health of members of society. Knowledge in medical sciences was used to introduce preventive measures. The use of such measures made crippling diseases such as malaria, bubonic plague, small pox, diphtheria, scarlet fever, poliomyelitis, et cetera, almost vanish from our societies. The same inventiveness, the same technology, the same skills of organization which were applied in the prevention of physical diseases have not been applied to the prevention of crippling mental and emotional disorders in children as well as adults. It would be an interesting task for anthropologists, sociologists, and social psychologists to examine the reasons why the discrepancy between applying existing knowledge, skills, and the same know-how and organization to the prevention of mental disorders in childhood and to the eradication of crippling physical diseases in childhood. Is it indifference? Is it hidden resistance?

It is true that prevention of mental illness is a far more complex undertaking than was the prevention of physical illnesses. It is true that we still do not know enough, at the present time, to prevent the many crippling diseases such as infantile autism, the schizophrenias, and certain other congenital mentally and emotionally crippling afflictions. But we know far more how to prevent, in such instances, crippling effects through intervention in early infancy than we have been willing to apply. Above all, we know far more about how to help children grow and develop into well-functioning, mature adults than we have been willing to apply in the past.

In speaking of prevention in the child mental health field, we need to keep in mind three broad areas where we have sufficient knowledge to apply either primary or

secondary prevention through intervention early in life, long before or immediately after birth. The three areas where prevention can do a great deal are:

1. Frank mental illness such as schizophrenia, infantile autism, and a small number of other crippling congenital emotional and mental handicaps. In this case a great deal more could be done through secondary prevention than we have been doing through intervention in early infancy, during pregnancy through prenatal guidance.

2. The other category is the average mentally healthy population of children for whom a great deal more can be done before and after birth, during early infancy and early childhood, and throughout the developmental years by promoting vigorous mental health and to reduce potential vulnerability in later years.

3. Thirdly, a very large segment of our population consisting of people wearing a mask of average mental health behind which are hidden many and various deficiencies in mental health.

This last category includes large numbers of the population who do not carry a label of frank mental illness, do not occupy hospital beds as mentally ill patients, and who do not appear in the statistical reports on the incidence of mental illness. However, behind this mask of normality are hidden many and different faces with a broad spectrum of crippling emotional disorders ranging from those which interfere with one's pursuit of happiness in his personal life but without interfering with his

functioning as a productive member of society, to the many ways in which absence of positive mental health can express itself variously in costly crippling physical illnesses. In the first instance, we are dealing with emotional problems of a minor or major neurotic nature; and in the second instance, we are dealing with emotional problems that are expressed in many kinds of physical complaints about the digestive, the circulatory, the respiratory, and the musculoskeletal systems. There are no parts in our complex body systems that cannot be affected adversely or beneficially in the performance of normal functioning by emotional factors, i.e., of a psychological nature. It is a safe assumption that people belonging to this category may number in the tens of millions and probably fill most waiting rooms of medical offices, and the beds of medical and many surgical hospitals. The cost in suffering, and in financial burdens, to individuals and to society is staggering.

Another subgroup belonging to this third category are the people with histories of periodic absenteeism in employment, of accident proneness, of self-destructive urges, the pill swallowers, the nostrum users, the drug users and abusers.

Another group on the same spectrum are the truants from life, the withdrawn, the inadequate, the unproductive, the delinquent, the chronically complaining, the quarrelsome, the litigious, the drifters, and many others.

Violence is another face of people who wear a mask of mental health. The face of violence in its many forms and manifestations is probably the best known and had the most destructive consequences to the individual and to society. It expresses itself in child abuse in its many forms, in deviant sexual behavior and a variety of many perversions, in suicide, and in homicide.

Violence in its many forms is the most familiar and the most ubiquitous face in the history of civilization. From the vantage point of a child mental health professional, it is, primarily, a deeply rooted psychological phenomenon, rooted in the history of evolutionary adaptedness. On the long road in our evolution from reptilian and mammalian brains to the human forebrain, we have retained residual parts of the former two brains--the reptilian and mammalian brains--in the forms of the limbic system and midbrain. Unlike another part of the body which evolution has forgotten to dispose of--our appendix--which has no function to perform at the present time, the limbic system and the midbrain have still to perform certain biological functions in our daily life. Like the appendix, when inflamed, becomes a life-threatening danger to the organism, the reptilian and mammalian brains, when not functioning in tandem with and in the service of the human forebrain, can become a life-threatening danger by its primeval urges, not only to the individual but to many members of society and to the survival of society itself. But, unlike the appendix which can be surgically removed when it becomes a danger to life, the primitive brain parts cannot be surgically removed when they become a danger to life. They cannot be surgically removed or disconnected without destroying life itself or without reducing man to vegetation.

At the present stage in our civilization there are only psychological means of dealing with the many problems of a psychological nature which man is facing and which are part of the human condition. The history of education, the history of our religions, and the history of our many social systems is the history of how to deal with the many conflicting, often other and self-destructive urges, arising in our biological organism and which, in advanced societies, have become mostly sociological problems.

If one were to put the Judeo-Christian religion under a high-power lens of a microscope and make a minute microscopic analysis, one would find that mental health principles are the essence of these religions.

The concern for the mental health of individuals of a society is as old as history of civilization itself. At any given stage of our civilization, we have used the means available to us to promote the well-being of the individual and the physical and psychological survival of our society. Education, religion, and the family have been the three major institutions which in the past have served in the service of the mental health of the individual and of society. In our present stage of civilization compulsory education has led to a lopsided progress in promoting affluence and the survival of our society through the potential use of enormously effective destructive technology. The other two institutions, the family and the religion, have become weakened in their relevance to child mental health.

By mainstreaming child mental health--by making it a part of and integrating it with compulsory education--as suggested in this report, child mental health would take top priority in our efforts to rearrange our present value system practices and may well determine the kind of society we will become in decades to come. By introducing child mental health in our school system, the training of teachers skilled in mental health will be only part of a national effort. The focus on child mental health will bring about a new focus in our orientation towards child caring and people caring. The well-being of children and people could become a major concern of our society and may lead to the betterment of the human condition, just as compulsory education has led to spectacular advances in our technology. It may

lead to reactivation and reinforcement of our two other institutions: family and religion.

From the vantage point of a child mental health professional, the mental health of children in its many different forms: developmentally, educationally, psychologically, socially, physically, should have top priority. A fraction of the billions now spent by our society on deodorants, cosmetics, on consumption of alcohol, cigarettes, and various nostrums, if spent on application of our present knowledge to the mental health of children, could give our society a new child-oriented direction and a reordering of our priorities and value systems. A prerequisite for such a massive effort would be the training of large numbers of child-oriented, child-centered, new professionals, to be trained for direct work with children and adolescents, to become knowledgeable, competent, and skilled in dealing with all aspects which lead to a child's growth and development along educational, psychological, and social lines, towards functioning as a mature, creative, and competent human being. The Child Mental Health Specialist was conceived to fill this role of a dynamic, process-thinking, system-oriented, versatile agent of change.

The Training Project, supported by a NIMH grant, was a small first step in this direction. The success of the Project should not be an epilogue soon to be forgotten when the final report has been filed on a few inches of shelf space in a library. The success of the Project only will have real meaning if the present report would serve as a prologue to many other child mental health and teacher training programs, and if child mental health is placed in the center of our national effort.

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APPENDIX II: Child Mental Health Specialist Training Manual

APPENDIX III: Evaluation of Training Program by the Center for the Study of Evaluation, UCLA Graduate School of Education, Los Angeles, California, May 1976

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